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THE MEDICAL JOURNAL OF AUSTRALIA

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The Journal of the Australian Branches of the British Medical Association.

VOL. I.—4TH YEAR—No. 8. SYDNEY: SATURDAY, FEBRUARY 24, 1917. PRICE 6D.

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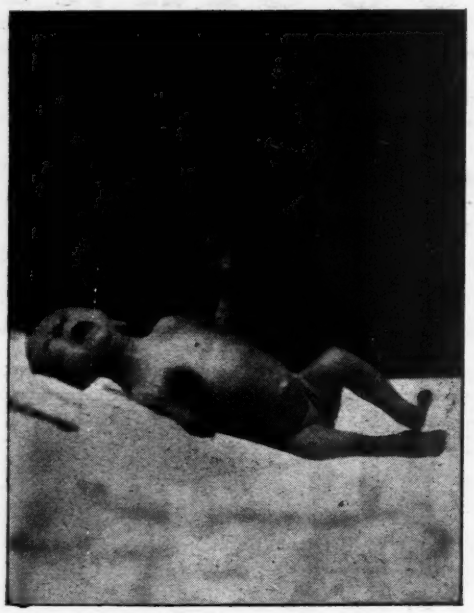
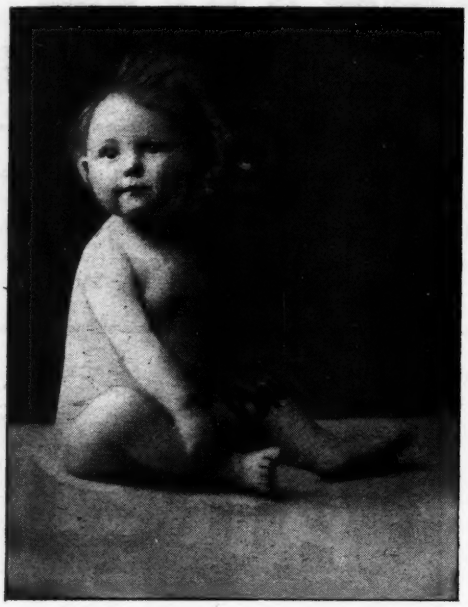


Before Virol.



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Baby Arnold, one of twins, born 29th December, 1912, was very delicate from birth and gradually wasted. At six weeks the case was looking very hopeless, but the Mother was advised to put the child on Virol; she began to improve at once, there being a notable difference at the end of the first week. The improvement continued steadily. The second photograph was taken when the child was 15 months. She is a bright healthy baby, full of life and gives no trouble.

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—4TH YEAR. SYDNEY: SATURDAY, FEBRUARY 24, 1917. No. 8.

HINTS ON LIFE ASSURANCE.[1]

By J. C. Verco, M.D.,
Consulting Physician, Adelaide Hospital.

The Council at its last meeting requested me to write a paper on life assurance, in which to embody any hints to medical referees which a long experience might suggest. For more than 38 years I have been examining proponents in this State, and for more than 30 years have been State Medical Referee for one society, to which my experience has been solely confined during all this latter period.

Proponents come before a local medical referee, who enters on one page of a printed form their personal statement—what they know about themselves and their family. This is signed by them, and witnessed by the doctor. Then he examines them thoroughly, and records on another page of the printed form his medical report; next he writes out a general summary on the third page of the form, expressing his opinion as to their health and constitution, and adding any explanation he may deem fit. He places them in a "first class" if they are average lives and free from special risks; in a "second class" if they are immediately assurable, but should be loaded, 3, 5, 7 or 10 years for some extra risk from personal or family history or physical condition; and in a "third class" if their lives are not assurable at present, but should be deferred for a term.

This printed form, dated and duly signed, is promptly forwarded to the office. Here it is critically scrutinized by the new-business clerk, who notes deficiencies in the information supplied, inaccuracies, or points specially adverse or favourable to proponents, and compares it with other reports sent in by the canvassing agent, and two friends nominated by proponent. These are now all passed on to the chief referee, who examines them from the medical point of view, analyses the report of the local referee, compares it with that of the agent and friends, weighs the recommendation as to classification, which he confirms or modifies. The office may be asked to obtain, if possible, additional information required either from proponent, the referee, or a doctor who may have previously attended proponent, or from the Registrar of Deaths in reference to relatives. When this has also been taken into consideration, the final recommendation is made by the Revising Medical Referee, and the case is sent on to a small committee for acceptance or rejection.

This printed form is a legal document, and forms the basis of the contract of assurance between the company and proponent. It is liable to appear in a court of law, where the referee may have to answer for anything it contains. It is well, therefore, to fill it in carefully, and see that proponent's signature is properly witnessed, and that no slips of the pen occur.

In life assurance a medical man occupies a delicate position. He is employed by a company which is desirous of securing as many policies as possible and yet resents recommendation of proponents who do not fulfil the average expectation of life. He must be careful not to be so strict as to exclude what is up to the average, nor so lenient as to admit what is really below it. Proponents are brought to him generally by a canvasser, who, if they are rejected, has no reward whatever for the time and labour he has spent in getting their proposal. He does not appreciate this, and if the examiner is too particular he will find the canvasser's patronage withdrawn from him in favour of a more merciful medical man. Proponents also come desirous of assuring, and they are pleased when they pass first class, distressed if rejected, and annoyed if loaded or deferred. The referee is liable to be biassed by his sympathy and immediate interest in favour of as abundant and liberal acceptance as possible. The office, convassers and proponents will all be pleased with marked increase of new business; but if he passes in diseased or delicate lives, and their policies have to be paid too early, or if their prior or subsequent rejection by another company is discovered, he will be asked for explanations. Two guiding principles should be adhered to: (1) Examine and recommend without the slightest prejudice towards any of the three, but impersonally and judicially, not concerned whether the proponent will be accepted, but only whether he should be. (2) Forward the report confidentially to the office, without telling proponent or canvasser the tenor of the recommendation or the reasons for it.

The attitude of a proponent towards the medical man is distinctly different from that of a patient. The one wants to be accepted as a healthy man, the other to be cured as a sick man. The one will tell you all he must, and will most likely make the best of it; the other will tell you all he can, and generally make the worst of it. It is interesting to observe how much the one man forgets and how much the other remembers. And so the relation of the referee is different from that of the doctor. The former has to elicit all essentials, and be sure nothing is minimized or concealed. The latter has to eliminate exaggeration, and limit volubility and detail, while he misses nothing of importance.

The first point to be noted is this. The chief function of the local referee is to collect all required information about the case, as regards personal and family history and present physical condition, and set it down concisely, fully and exactly, so that revising referees and other officials can assess the risk properly. He makes a recommendation as to assurance and its classification, and this carries weight, varying, of course, with his reputation and his reasons. With reference to some circumstances, his

[1] Read at a Meeting of the South Australian Branch of the British Medical Association on August 31, 1916.

recommendation cannot be called in question. If he states that the proponent is so anæmic or so delicate-looking or bears such marks of intemperance that assurance must be postponed, his recommendation must stand. No definite data can here be furnished to guide the chief medical officer, who would have to interview the proponent personally before traversing such an opinion.

But in many cases his recommendation must be set aside, for one or more of several reasons. (1) He has not all the necessary documents before him, such as the reports of the agent and the friends, or the papers of some previous proposal, which may reveal what the proponent may conceal. (2) He may have a very limited experience in life assurance work. (3) He may be unacquainted with the policy of the particular office for which he is examining. Some assure patients with organic disease, others not; some load for family history of phthisis or cancer, others not. It is therefore no reflection upon a local referee if his recommendation is altered. And if he has given all information in reference to the proponent necessary to enable a proper assessment to be made by its officers he has done all they really require. In fact, a very good plan is sometimes to intimate that the life is not first class, and that the assessment of risk is left to the discretion and experience of the revising medical officer.

In the personal statement the actual name should be written out in full at the top. At the bottom may be appended the proponent's usual signature.

Occupation may involve risk, especially if it exposes to poisoning, as, for instance, by alcohol or lead. Consequently, publicans and barmen and cellarmen and brewer's men are not select lives. It is necessary to enquire whether a publican's wife, if she is the proponent, serves in the bar, or lives in another part of the house altogether; also in what work the brewer's man is really engaged at the brewery; and in all these cases to look for physical signs of intemperance.

So in smelters and silver-lead miners, the blue line on the gums should be sought as proof of poisoning in some degree, and a note made as to what special department of smelting the man is engaged in, whether feeding the furnace with ore or fuel from above, or tapping it from below, when he would be specially exposed to lead fumes; or in some other capacity where he would be free from these. And if a miner, whether he works in an "open cut" in the pure air, or underground in the drives.

Enquiry into previous illnesses, injuries and operations covers a very wide field, but can be conducted fairly quickly; a long category of complaints is divided into convenient groups. Here the referee exercises due discretion to avoid wasting time in recording unnecessary details, and to omit no information of moment. He is directed to note briefly the nature, dates, duration and termination of any illnesses experienced. This may seem rather much to ask, but in most instances it is requisite, and if left out the referee will very probably receive a memorandum from the office asking him to supply the omission.

This personal history carefully sifted by a qualified medical man forms a most important part of the data for a confident assessment of the prospects of life; and a practitioner may show his insight into this subject by the manner in which he records relevant points in respect of the several complaints experienced. Each should be regarded not merely as an incident in the past history, but as a forecast of future longevity, and those circumstances should be elicited and entered which have direct or indirect bearing on this question.

For instance, if the proponent had measles in childhood or enteric fever ten years before, its exact duration and termination need not be noted. But suppose he had pleurisy, it is of consequence, whether this occurred ten years before or two, whether he was in bed with it a few days or several weeks, and whether it was a "dry pleurisy," which often means only a rheumatic myalgia, or whether it was pleurisy with effusion, requiring one or more tappings, and which so often is followed by pulmonary tuberculosis, and so is a recognized risk to life.

Take another example: "Have you at any time suffered from spitting of blood?" "Yes" is no sufficient answer. We need to know how long ago, what was its duration, did it recur, and if so how often, and when last, how much blood was raised, and what was the cause of the bleeding? It may have been only a faint streaking of phlegm in a remote acute bronchitis, or sanious sputum in a pneumonia; this would involve no future risk. But it may have been a profuse hæmoptysis, without evident cause, within the last few years, or recurrent. This would be of serious significance. It might have immediately followed a severe muscular strain, and that years ago, and not have been repeated, the gravity of which would be slight.

So with fainting. When did he faint, and why? Healthy people may faint if injured, or at sight of blood, or some distressing incident; if without evident cause, he must be weak in some way, or he has not faints, but fits; if frequent or periodic they are probably epilepsy; seek for evidence of this, so as to form a definite opinion, and state it, with its reasons.

"Have you had rheumatism, gout, or rheumatic fever?" "Yes" is not enough. If it was rheumatism, when was it, what was its nature, lumbago, sciatica, stiff neck, or affected joints? Was he laid up with it, and was he feverish with it? If not, it is of slight consequence. If, on the other hand, it was rheumatic fever, how many times has it recurred, when was the first and when the last attack, what was its severity, how long was he confined to bed? For if he is still young and has had a recent severe attack, especially with previous occurrences, the prognosis is serious. If his heart is not already affected (in which case he would not be assured), he is liable to recurrence, which may cause *morbus cordis*, and markedly shorten his life. If, however, he has reached middle life and has had only one attack, and that in childhood or youth, the risk is insignificant, and may be ignored. Enquiry along such lines, and record of such salient points, makes the personal statement valuable, their omission makes

it worthless, and necessitates further investigations and correspondence.

Have you had discharge from the ears? If once only, when a child, for a short period, after measles, it is trivial. If occasionally with a bad cold, soon ceasing, and none for years, it is unimportant. If somewhat chronic but quite cured by removal of post nasal growths, or after definite treatment, and none for years, it carries no risk. But if present now, of some months' duration, even though slight, especially if purulent or fœtid, it is a menace to life; it may be associated with bone disease, or may set up meningitis, or sinus thrombosis. If present now, but only of short duration, and associated with catarrh in the throat, it may pass off in a week or two, and it may not prevent acceptance then.

In the family history give the ages of parents, if alive, and the state of their health; as also of all brothers and sisters. If any are ill, note their complaints, some of which, such as phthisis, epilepsy, insanity and asthma, may have a bearing upon the proponent's prospects of life. If any are dead, note the age and cause of death, and the duration of the fatal illness. The latter is often of importance. If from bronchitis or pneumonia or pleurisy, lasting only two or three weeks, the duration confirms the cause as an acute disease. But if lasting three, or six, or even twelve months, possible phthisis is suggested. In these circumstances where there may be a doubt and even a suspicion about the death, the deceased's name and age, and place and date of death should be given, so as to allow the certified cause of death to be obtained from the Government Registrar.

The cause of a mother's death is often given as child-birth. Then the interval between her delivery and her decease should be given. Child-birth is no real cause. It is a natural event. Death must be due to some accident or disease. If death occurred within a few hours to two or three weeks, it was probably due to some catastrophe, such as hæmorrhage, or to puerperal fever. But if not for months, the cause may be quite unconnected with delivery. As a fact, it often proves to be phthisis, disclosed by the death certificate.

In cases of violent death, such as gunshot, drowning, poisoning, or overdose of narcotic, an endeavour should be made to discover whether this was accidental or suicidal, because in the latter case a loading will be imposed.

The occurrence of what are regarded as hereditary diseases, namely, consumption, asthma, gout, cancer, diabetes, epilepsy, insanity, suicide in other relatives (uncles, aunts, cousins, husbands or wives) should be recorded. If such a remote family history exists, it accentuates any occurrence of the same complaint in the immediate relatives, or in the proponent himself, and would vindicate a loading, which, apart from the remote history, might be scarcely justifiable. For instance, insanity in a mother, coming on with child-birth, and recovered from, might be disregarded; but if some of her brothers or sisters had also been insane, her insanity being familial would more likely be hereditary. If insanity in a father or a mother can with some certainty be traced to drink, or to a head injury, or to some organic disease, such as chronic kidney trouble, apoplexy, cerebral tumour or syphilis, a loading may be dispensed with.

If a woman's husband has phthisis, or has recently died from it, she should be loaded. Her liability to the complaint is doubled by this circumstance. If a man's wife has phthisis, or has recently died from it, he need be only very lightly loaded, because he is not in such danger. If a proponent is living in the same house as a phthisical patient, enquiries should be made as to the closeness of association, and whether proper precautions are taken against infection; the same applies to infectious fevers, as enteric fever, scarlet fever and diphtheria; and if these exist in the same house, assurance should be postponed till danger of infection is passed. I once examined a boarder from a house where another man had enteric fever. He was accepted "select," paid his first premium, and died of typhoid before his next premium fell due.

The intent of all these questions is to ascertain concerning each item every fact bearing on the probable duration of the proponent's life; whatever can influence this should be clearly set forth.

The Confidential Medical Report.

The important point to be remembered in reference to the medical report is this. Each item should be so filled in as to enable the chief medical officer to recognize from the referee's statements what is the actual condition of the several organs of the body, whether quite healthy, or if diseased, the exact nature and degree of their abnormality, and the state of the general constitution. Hence his statements should be sufficiently full, quite clear, and yet concise. He is not talking to a patient, but writing to a medical officer, who understands technical terms, and the nature and physical signs of disease. In an ideal medical report the chief medical officer should be able to see at once why certain organs are said to be diseased, and why the referee makes his recommendation as to acceptance, loading or postponement. For instance, in reference to the lungs, any adventitious sounds heard should be described and located, any asymmetry of the chest, abnormal percussion resonance, vocal resonance, or respiratory sounds. To affirm merely comparative exaggeration of breath sounds or vocal resonance at the right apex is useless, because it is quite usual. If anything abnormal is found and noted, its significance and explanation if possible should be given. Of what use is it to write simply "the lungs appear to be weak"; if the lungs are said to be unsound, the evidence of their unsoundness must be written down in terms of abnormal physical signs.

So with the circulatory system. The rate of the pulse should be given, and if too high, should be explained. Nervousness is often the cause, or hurry. By feeling it again later during recumbence it may be found to have quieted down, and this should be stated. If irregular in rhythm, or intermittent, it should be felt again after rest, or after the active exertion of forced breathing or working of the arms. If persistent, a cause should be sought in indigestion or a dilated or fatty heart. A very slow pulse

of 50 or 44 may be quite normal to the individual, and on enquiry may prove to be a peculiarity known to him, and of long duration, even congenital. An abnormal site of the heart's apex beat should be explained. One referee found it on the right side of the chest, and without any suggestion as to its cause recommended three years' loading. This was impossible. If due to disease present or remote, three years would not cover the risk. On examining the proponent I found, as suspected, transposition of viscera, and passed him in as "select." So with abnormality in force. It is often due to excitement, and may disappear with reassurance or recumbency. Sometimes if the proponent is very nervous it does not pass away, then there is often an exaggeration of the heart sounds, and sometimes even a systolic murmur, probably a safety-valve regurgitation of an excited heart. All you can do is to note and explain the condition and get the patient to call again for another examination, when, being familiar with the proceedings, his heart may be quiet and natural. If it is just as bumping and quick and noisy and unnatural as before, all you can do is to defer him for a month or two, and hope it may be quieter next time. Any murmurs heard should be recorded with their rhythm, their site and their intensity, in as few words as possible. If heard at such places, and of such quality as to seem hæmic, say so, and give an appropriate recommendation. To say only in a general way that the heart seems to be affected is not enough. Some societies accept proponents with organic disease of the heart and load them heavily; other societies will not assure them under any conditions. If you describe the state of the organ definitely, and give your opinion as to the nature of the disease, the chief medical officer can make what recommendation the policy of his office allows.

Note the existence of varicose veins and varicocele, and do it as definitely and comprehensively as possible. A difficulty is felt here by the chief medical officer, owing to the diverse personality of referees. Some are alarmists and exaggerators; others have common sense. One proposes a three years' loading for a "very large varicocele," which, when seen, is found to have shrunk to quite a moderate or even small size. After a while a chief medical officer becomes acquainted with this style of referee, and, "knowing what manner of man he is," discounts his enormous proportions somewhat.

As to hernia, we used to load for it, but now if the proponent wears a well-fitting truss and signs a declaration that he will continue to do so, he is accepted "select." One thing required is to see if the testis is absent or in the scrotum, or in the inguinal region, or in the canal. In the latter two sites it involves a loading owing to its liability to injury and operation and to become associated with an awkward rupture, which, if present, is often difficult to keep up with a truss, owing to pressure on the testis.

The urine should be examined in every case. Its specific gravity is to be noted, and if very high or very low, is to be explained if possible. Albumin and sugar have to be tested for. I think the acetic acid, brine and heat test is the best for the former, and quite sufficient, and Fehling's for the latter. In my presidential address I discussed the method of deciding whether a slight reaction for sugar in high specific gravity urine meant pathological glycosuria or not. A trace of albumin found in young people under 25 deserves comment. When found, the heart should be specially examined for outward displacement of the apex, forcible impulse, booming sounds, accentuation of the second sound at the base, the pulse for high tension or thickened arteries, and a sample of urine passed on rising for albumin. If none of these are found, nor any other evidence of disease, so that the referee is satisfied the trace of albumin (which may be intermittent on different days) is "functional," "postural," "intermittent," "adolescent," etc., no loading is imposed. So if a slight cloud is found under 25 years, make these special investigations at the time, and state your opinion that it does not indicate chronic nephritis, and the case will be accepted "select."

Height and weight must be recorded. Whether these are the statement of the proponent, or an estimation by guess, or actual measurements by the referee should be so indicated. There is a recognized average weight for each height, varying according to age. A range of about 15% below this average and of about 25% above it is regarded as within the limit of health. Beyond this limit a loading is usually imposed, although a physique, with personal and family history which are faultless, as also a marked family tendency to the same peculiar leanness or fatness associated with longevity may allow remission of such loading.

Sometimes a history is given of an illness of doubtful nature. If this seems to have been of such sort as to involve possibly some considerably risk, it may be necessary to ask the office to obtain a report from his personal medical attendant. Unless, however, it seems likely that he will be able to supply information unobtainable from the proponent, and so help to decide the influence of this illness on his longevity, do not ask for a report, because it delays proceedings and costs an extra guinea. If it appears necessary or desirable it should be requested.

The General Summary and Confidential Opinion.

Here the referee has to state his opinion as to the constitution and health of proponent, and to recommend acceptance as a first class life, sometimes spoken of as "select," or "at table rates," or "rate for age"; as "second class," that is, acceptance at once, with a loading varying in degree from three years to ten (this means that if he is 20 years next birthday he will have to pay a premium as though he were 23 or 30 years old); or as "third class," that is, a deferred life. The term for which the policy may be postponed varies. If a man over 35 has albuminuria, and it is present on a second and third testing, he will be deferred for three months. A man with a bad influenzal cold may be postponed until his cold is gone; one with appendicitis until two years have elapsed since his attack; after appendicectomy for six months; with *morbus cordis* for five years. The latter term is equivalent to infinity. Some offices never reject any proponent,

they defer them for five years. This does not depress them as absolute rejection might, and so inflicts no physical or mental injury, nor does it prejudice so much an application to another office.

Explanatory memoranda are asked for in the general summary, and should not be omitted. It is well to state why the patient is loaded, or why he is not, instead of leaving this to be inferred. These memoranda should be relevant, and not a prolix screed without much bearing on the case. They should be concise and at the same time should contain adequate discussion of *pros* and *cons*. If a referee is uncertain as to what loading should be added in connexion with any disease or abnormality found, it is well to say that the exact assessment will be left to the society's chief referee. This is not regarded as in any way a shirking of duty, or an evidence of incompetency, and does not imperil his position as local or occasional referee. Of course, it is better to try and assess as consistently as possible, and so rise in the esteem of the office, and show fitness for the higher post. If a referee should feel that he cannot be sure as to the presence or absence of organic disease of the heart or lungs, etc., in any case, he should say so, and recommend a special examination by the chief referee, and this will not be taken amiss by the company. Of course, it should not occur too often, or the referee will be proclaiming his own lack of confidence in his ability to examine.

It is well not to be too familiar or too expansive in writing these memoranda. One medico, whose mental condition, as well as its cause, would probably not be very difficult of diagnosis, wrote: "I hate this man's father like the very devil, but I am not going to let that influence my recommendation; accept him first class."

Another referee's memorandum ran as follows in the case of a proponent, aged 33, whose mother some twenty-five years before had died at the age of 34 of consumption of twelve months' duration following pneumonia: "From the proponent's present excellent state of health it would be interesting to have authentic information whether his mother's pulmonary trouble was specific or not; she was pregnant at the time of illness, and that child is healthy and still living. The mother's illness came on acutely after a thorough wetting; her death occurred within twelve months, which, if tubercular, was virulent, and other members of the family could not have escaped infection. Her history, as given, points more to perhaps influenzal or septic troubles following a pneumonia, in which her lung proved resistant to a true pneumococcus formation, and gave rise to the *streptococcus viridum* or perhaps *haemolyticus*, and resulting abscess of lung. Her death certificate would be interesting." Possibly! but it would cost a shilling, and for insurance purposes (as the proponent stated his mother died of consumption) would not be worth that amount of money.

To discuss *seriatim* all the questons in a printed insurance form, and the loading which should be affixed to every flaw in the physical condition and personal and family history of a proponent, would mean writing a volume on life assurance. I trust I have in the time at my disposal thrown out a few hints which may be of use to medical practitioners called upon to examine occasional cases.

A SIMPLE INHALER.

By **Leonard W. Bickle, F.R.C.S. (Edin.),**
Korrumburra, New South Wales.

Any method that is likely to bring relief and possibly cure to the sufferer from pulmonary and laryngeal tuberculosis, or possibly to lessen the chance of conveying it to others is worth consideration.

Some years since Dr. Lees, of St. Mary's Hospital, drew attention to his method of continuous inhalation as a means of treatment. The results have been good, I believe, in many cases, but it has the objection that the apparatus is clumsy and unsightly. Before he brought his method forward I had been in the habit of using frequent inhalations with benefit by the method here described.

In the several voyages made since November, 1915, with troops, I have had several opportunities, unfortunately, of using my method. It has commended itself strongly to my colleagues as well as to the matrons and their nursing staffs on account of its simplicity and cheapness.

The inhaler is simply a new wooden pipe—if for male patients preferably with a cover. A small piece of absorbent wool is lightly packed into the bowl of the pipe like a plug of tobacco. The wool is saturated with the inhalant preferred, and the patient is directed to draw in air by the mouth and then closing the lips on the stem of the pipe (or removing it as preferred) to breath out through the nostrils. The process can be repeated as often as desired, the only essential being that the expired air is not forced through the pipe. Once a day is often enough to change the wool, but fresh supplies of the inhalant can be added at frequent interyals. Of course it is a dry smoke, *i.e.*, it must not be lit; this is one reason for using a cover with men. A man does not mind being seen with an unlit pipe in his mouth, the cover prevents the wool being seen, especially if the inhalant be dark enough to colour the wool.

A favourite inhalant of mine is:

R. Bals. Peruv., 4.0
Ol. Eucalypt.
Ol. Pini Sylvestris āā ad 32.0
Fiat guttae
Signa: Use as an inhalant as directed.

Of course guaiacol, creosote or iodine can be used, if desired. In laryngeal cases a special inhalant containing chloroform can be used before taking nourishment, when, as is so often the case, that becomes painful.

All patients say that the method is very soothing to the cough; it lessens expectoration, and they feel more comfortable. One lady patient, the wife of a Baptist minister, who benfited much by the treatment, as she was getting better and able to attend

Dorcas and similar meetings, used to delight in shocking the feelings for the moment of visiting lady members by saying: "It's time I had my smoke," producing her pipe at the same time. Needless to say the horror quickly changed to keen and sympathetic interest.

Another possible advantage, and one which I should like to get confirmed, is that theoretically the bacilli in the sputum of those using this method should be killed or markedly reduced, thus rendering the sputum less likely to be hurtful to others. Perhaps someone in the position to make observations would use the method and report on the results both as to the benefit to patients and its effect on sputum.

Reports of Cases.

ULCERO-MEMBRANOUS STOMATITIS.

By **H. Seaward Marsh, M.B., Ch.M. (Syd.),**
Honorary Assistant Surgeon to the Ear, Nose and Throat Department, Sydney Hospital, and St. Vincent's Hospital, Sydney.

A sailor applied at the St. Vincent's Hospital, Sydney, for treatment of a sore mouth and throat. When I saw him he was suffering from gingivitis and stomatitis. There was an ulcer on the right tonsil and superficial ulceration of the inside of the lower lip and on the mucous membrane of the cheek opposite the third molar teeth of the upper and lower jaws on the left side. The breath was very foul. There was considerable pain and discomfort. A Wassermann test of his serum proved negative. I therefore prescribed the following solution, which was recommended for pyorrhœa by the author of an article which appeared in a recent number of the *British Medical Journal*:—

R.

Vin. Ipecac.	24.0
Glycerini,	6.0
Liq. Arsenicalis ad	30.0

Misce.

Signa: The Application, not to be swallowed.

This solution was swabbed by means of a small applicator all round the roots of the teeth and on the ulcers twice daily by Dr. Lamrock, the Resident Medical Officer. Ten drops were placed on a badger hair tooth brush and the patient scrubbed his teeth and gums twice daily in addition. Dr. Lamrock reported after the first application that the patient had experienced great relief. In a few days the condition was considerably ameliorated. I saw him about a week after the treatment had been begun. The ulcers of the tonsil and lip had disappeared, and the ulcers opposite the third molar teeth had almost healed. All the gingivitis had cleared up. There was still some pyorrhœa of the lower incisors, where tartar was present. The treatment appeared to have been a specific for the condition.

In the October number of the *Journal of Laryngology*, there is a report of a paper by Fred. B. Bowman on ulcero-membranous stomatitis and gingivitis among troops in England and France. The author of this paper points out that this is a communicable disease, and that it is due to Vincent's organism, though streptococci and amœbæ are also present. He adds that the throat condition cannot be distinguished clinically from syphilis. It may be diagnosed as syphilis, mercurial stomatitis, diphtheria, *pyorrhœa alveolaris*, etc., according to the form assumed. Sometimes the gums and mouth have the same appearance as in scurvy. He found that the condition could be cured readily by applications of arsenic and ipecacuanha solutions. The ipecacuanha is used on account of the presence of amœbæ, and the arsenic for the spirochætes of Vincent.

I believe that my case was of the same nature as those described by Frederick B. Bowman.

Reviews.

MICROSCOPIC ANATOMY.

The tenth edition[1] of the "Essentials of Histology," by Sir Edward A. Schäfer has appeared just thirty-one years after the publication of the original issue. The book is intended for a guide to the study of microscopical anatomy. It contains sufficient directions for the preparation of animal tissues before examination with the microscope to enable the intending student to supply his own specimens. In addition the book serves as an elementary text-book of histology. Descriptions are given of the various tissues and organs of the animal body in such detail that each lesson contains not only an account of the specimens to be studied but also a survey of the essential features of the minute anatomy of the group of structures dealt with. The way in which the manual has fulfilled the design of its learned author is attested by the use made of it by almost every British and Australian student of histology during well-nigh thirty years. This success is in part due to the careful manner in which each new edition has been brought up to date. The tenth edition, like its predecessors, bears signs of a well-considered revision. The results embodied in recent monographs and papers, are incorporated in the text. The illustrations have received special care. Many reproductions from photo-micrographs of instructive preparations have been introduced. These photographs have been chiefly taken from microscopic specimens made by the author or his pupils. The visual effect of some of these figures has been improved by printing them in colour.

The coloured blood-corpuscles are described as consisting of a delicate colourless envelope and coloured fluid contents consisting mainly of a solution of hæmoglobin. The external envelope forms a thin film enclosing the dissolved coloured material. The effects of reagents on the erythrocytes are ascribed in part to osmotic action and in part to the solution of the encompassing membrane which contains lipoid substances. Hypotonic salt solutions do not, however, give rise to swelling of the corpuscles unless the concentrations of the solutions are considerably below the isotonic strengths usually accepted. The corpuscles are filled with material in the colloid state, so that the phenomena of absorption will play some part in the reaction with dilute saline liquids. It is stated in this as in former editions, that basiphile leucocytes are rarely, if ever, found in normal adult blood, but occur in children and in certain pathological conditions affecting the bone marrow. In this country basiphile leucocytes may be found in every film of blood, though not present in great numbers. As a rule about one out of every 200 white corpuscles contains coarse basic granules soluble in water and in aqueous solutions.

The suggestion may be made that in subsequent editions, the directions at the commencement of each lesson be printed in heavier type. Students are apt to believe that small type betokens less important matter which may be neglected. As the whole of the practical instruction is given in the small type, it seems a pity to run the risk of it being disregarded. We may hope that this sterling work will long continue to be the standard text-book for students.

A list of casualties, the 272nd, was issued on February 14, 1917, and contains the names of 25 officers, 823 non-commissioned officers and men, four nurses and two chaplains. No medical man is mentioned in the list. In the 273rd list there is the name of one medical man under those ill in hospital—Captain R. K. Rae.

[1] The Essentials of Histology, descriptive and practical, by Sir Edward A. Schäfer, M.D., Sc.D., L.L.D., F.R.S. Tenth edition; 1916. London: Longmans, Green and Co. Sydney and Melbourne: R. Robertson and Co. Royal 8vo., pp. 563, with 729 illustrations. Price, 12s. 6d.

The Medical Journal of Australia.

SATURDAY, FEBRUARY 24, 1917.

Looking into the Future.

Thirty-two months ago, when the Empire engaged in warfare, the military authorities had no leisure to contemplate the problem of placing the disabled soldier in a favourable position to take up the ordinary tasks of life. There was nothing to guide them as to the number of these men or what would be required to enable them to fulfil their obligations to the soldiers. As time passed and the struggle became more and more protracted and more and more violent, definite ideas were formulated. It was apparent from the first that the State, this is, the community, must in the long run either provide treatment until the wounded and disabled man has derived as much benefit as present-day science can bring to him, and must fit him to follow a suitable calling, or it must make good and bear the burden of the man's support. Putting all thought of sentimental obligations aside, it was realized that both in the interests of the present and of the succeeding generations and for economical reasons every man must be restored to earning capacity with as much dispatch and thoroughness as possible. In the British Isles, the prospects of thousands of men with impaired activity needing assistance from the public for many years was disquieting. As the number of these disabled men swelled, the magnitude of any promising scheme impressed itself on the minds of those who had considered the question. Unfortunately, a start was not attempted until the need had become very pressing and large numbers of men were wasting valuable time unaided and without a proper guidance.

Some time back the War Office in England sought for expert advice on the questions involved in the problem of the disabled soldier. An Order-in-Council was issued appointing a Committee of Reference of the English Royal Colleges of Physicians and Surgeons. This Committee has now dealt with the undischarged, but dischargeable, soldier, and the advice tendered to the War Office forms the subject of an editorial comment in the *Lancet* of December 9, 1916. The Committee had to determine first of all what form of control should be exercised over those men who would require institutional treatment. They came to the conclusion that the conditions for success included the proviso that the patient should be placed under discipline, and that the best form of discipline was military discipline. In the next place they found that, in the large majority of these cases, institutional treatment was essential, and that this treatment must be prolonged until the best results have been obtained. In order to limit the liability, and also to render the scheme a practical one, they recommended that a maximum period of treatment should be fixed. The institutions favoured for this purpose are the military hospitals. The men are to be kept in hospital until they are fit to be discharged to convalescent camps. They propose that annexes to convalescent camps should be set up, where the treatment can be carried out by Royal Army Medical Corps officers, assisted by civilian doctors. The soldiers should not be discharged from the Army until treatment can do no more good, or until the maximum period has been reached. In connexion with special classes of disability, they suggest that supervision by special boards should be exercised.

In the Commonwealth the same questions have received attention for some time; but up to the present there has been a want of uniformity which lessens the value of the work. The appointment of the Federal Parliamentary War Committee was the first step. A Sub-committee of this Committee drew up a scheme on August 19, 1915, for the organization of the work of providing treatment for disabled soldiers. This led to the appointment of a Federal Medical War Committee and of six State Medical War Committees. The former was nominally responsible to the Federal War Committee, while the latter were to work with the collaboration of the State War Councils. In South Australia the State Medical War Committee has continued to carry out its duties since its appointment, limited by the terms of its reference and by the circumstances under which it was compelled to work. In some of the

other States the work has been practically continuous, while elsewhere difficulties have arisen which constituted a serious bar to progress. The scheme was not complete enough to give satisfaction in the long run. Some of the military hospitals have been organized in a manner leaving much to be desired, and instead of the patients being under that discipline which the English Committee of Reference considers essential for success, the soldiers do as they please, and avoid treatment, if it does not suit them. Moreover, there is no attempt to carry out a supervision of the work by a board of experts in the various special branches of medicine and surgery. Many of the military hospitals are under the control of excellent general practitioners, who attempt to act as general surgeons, physicians, eye specialists and so forth. Another defect in the system is that each State can make its own arrangements, with the result that uniformity is lacking, and the care extended in the area of one military district is less good than that extended in another. A collaboration between Army Medical Corps officers and civilian practitioners, such as is proposed for Great Britain, is unnecessary for Australia, provided that every medical practitioner of under 60 years of age can be pressed into the service. The Federal Medical War Committee would be doing sterling service to the Commonwealth if it were to draw up a comprehensive scheme including the establishment of special services under expert control, such as an orthopædic, a neurological, an ophthalmic and other services, and would press for one quality of treatment for our disabled soldiers—the best.

NOTIFICATION OF DISEASE.

In our issue last week we published for the first time a complete record of the returns of notifiable diseases in the Commonwealth during a quarter of a year. The value of this summary is self-evident, and will appeal to everyone interested in the preventive side of medicine. We take this opportunity of expressing our indebtedness to the heads of the Public Health Departments in the six States for having supplied us with the information, which has enabled us to compile this table. It is proposed to continue this record each quarter, and to give successively the figures for one quarter, one half, three-quarters and the whole year. It is also proposed to publish the number of deaths from each of these notifiable diseases in the subsequent tables. It is probable that an error will be introduced by setting side by side the number of cases notified and the number of deaths, since many cases are not notified, many are notified on an insufficient diagnosis, and in many fatal cases the cause of death is either inadequately stated on the certificate or wrongly certified. In addition a number of deaths take place without any medical certificate being obtained, and the diagnosis is entered on the information given by the relatives. Notwithstanding these possible sources of error, the table should form a valuable guide to the incidence and mortality of infective diseases in Australia. At all events no more reliable information can be obtained until other means are adopted to secure more efficient notification of infective disease.

Medical practitioners are under a legal obligation to notify instances of certain infective diseases as soon as the diagnosis can be made with reasonable certainty. This obligation is too often taken lightly, and practitioners fail in their duty out of misplaced kindness to their patients, or from a dis inclination to earn the reputation of reporting every case of infective disease. This matter is too serious to admit of exceptions being made for personal or local reasons. The practitioner should remember that the information is required, not for idle curiosity, but for the purpose of enabling the health authority to trace the source of infection, and by employing reasonable means to check its spread. It is just as important that prompt notification should be carried out in sparsely populated districts as in crowded centres. While more persons are endangered by a "missed" case in a city, the possibility of wide spread is greater in country districts.

It must also be recognized that the public health authorities have a serious responsibility to the public. It is not sufficient for the public safety for the Health Department to be satisfied that their duty is completed when each notified case has been investigated, when "contacts" as well as infected

persons have been isolated and kept under control, and when objects which may cause the spread of infection have been disinfected. A keen look-out should be kept for unnotified cases. The diagnosis of the infection can always be checked if the health officer collaborates with the treating practitioner, and requests the latter to satisfy him that a mistake has not been made. More difficulty is experienced when a probable instance of one of the notifiable diseases is not notified. In this case, the health officer has no information to bring him to the practitioner in attendance, and under the most favourable circumstances some time must elapse before an indication is received by the Department. In the last place it appears to us that there should be uniformity both in regard to the diseases which are notifiable and in regard to the manner in which preventive measures are adopted throughout the Commonwealth. We have pointed out on various occasions that in matters affecting the public health there can only be one "best" method of prevention at a given time, corresponding to the state of our knowledge of the particular disease. It is a serious defect that the six departments can adopt six different methods of attempting to cope with a common danger.

NOT A SCRAP OF PAPER.

On numerous occasions we have reminded the members of the British Medical Association in Australia that shortly after the outbreak of hostilities a resolution was passed in every State in the Commonwealth pledging the members to safeguard the interests of those absent on active service, as far as lay in their power. The men who have accepted commissions and have gone abroad to serve the Empire have made sacrifices incomparably greater than the sacrifices entailed by a little additional work or by a little disturbance of the smooth flux of every-day practice. There are unfortunately men in every community who will succumb to the temptation of making a profit out of another's misfortune. To seek an advantage at the expense of men who are doing their duty at the risk of health, life and prosperity is even worse. Instances have been brought to our notice from time to time of medical men endeavouring to build up a practice out of the patients of men who have gone to the front. We hope and believe that this action is exceptional, and that it is undertaken without a recognition of the enormity of the offence. It may be tempting for men who are starting in practice, or who have reason to change their sphere of activity to select an area from which one or more of their colleagues have left to join the Australian Army Medical Corps. It is obvious that practitioners cannot be debarred from moving from one part of the Commonwealth to another, or from starting practice during the continuance of the war. But it must be insisted that no man has a right to build up a practice at the expense of his patriotic colleague, and that every member of the medical profession must honour the undertaking given in 1914. Men who ignore this pledge are unworthy of the profession to which they belong.

ELECTROLYSIS FOR CHRONIC GONORRHŒA.

Theoretically any localized specific inflammation caused by a known organism should be easy of cure, provided that the infected area can be reached without the production of a wound. The task should be especially easy if the causal organism is one of small resistance. But theory and practice do not always coincide, and the practitioner whose prognosis in gonorrhœa depends on what appear to be favourable conditions will often learn to his cost that he has been grasping at a shadow. In the case of the acute stage cautious application of the usual remedies may lead to success, but these remedies must be applied with knowledge, skill and individual adaptation to the case. Too often a microscopical examination of the urethral mucus will reveal the persistence of gonococci, and at times even when no gonococci are to be detected in the mucus expressable with the aid of prostatic massage, proof is obtainable that the infection has not been overcome. The gonococcus has the habit of finding out deep *rugae* and of invading the epithelial cells in inaccessible positions. If it is difficult to achieve disinfection of the urethra in the male during the acute stage, it is doubly difficult to cure the disease in its chronic stage, and in the female it may be almost impossible. Drugs taken internally have but little effect; vaccines are notoriously disappointing in this condition; local applications often do more harm than good, especially if continued too long; and bougies frequently fail to improve the condition in the least.

Charles Russ, writing in the *Lancet*,[1] recites his experience of treating these obstinate cases with electrolysis. His procedure in the ordinary chronic case with gonococci and pus in the discharge is to stop all irrigations and injections and to use electrolysis, first superficially and then more deeply. The treatment is applied every other day. At the same time he employs a gonococcal vaccine and salol or santal wood oil. The effect, as described by him, is most striking. After the irrigations have been stopped and a few applications of electrolysis used, the gonococci and with them the pus ceases. Gonorrhœal arthritis clears up without any additional treatment to the affected joint. In the more chronic cases, with a small amount of purulent discharge containing pus cells and bacteria other than the gonococcus, he avoids electrolysis at first and attempts to clear up the contamination by giving a vaccine prepared from the bacteria found in the discharge. When the secondary infections have been overcome, he uses his electrolysis, if necessary. When a stricture and a discharge are present, he uses a small current, as the constricted urethra may contract on the catheter and prevent its withdrawal without the exercise of considerable force. As it is important that the urethra may not be damaged, for obvious reasons, other means must be employed to liberate the retained catheter. The application of a strong reversed current or the installation of a small quantity of 2% solution of stovaine will secure this. He offers no suggestion as to the rationale of the treatment. From the available data it would seem that heat plays an important part in the bactericidal action of electrolytic currents. More knowledge, however, is required on the precise nature of the changes, both physical and chemical, which take place when electrolytic currents are passed through living tissues.

VERATRONE IN THE TREATMENT OF ECLAMPSIA.

The favourable impressions received after the exhibition of veratrone for eclampsia have led to a comparatively widespread employment of this drug. It is a solution of the massed active principles of *veratrium viridi*, and its dose by hypodermic injection is from 0.125 to 1 c.cm. In the treatment of eclampsia it is given in full doses. W. F. T. Haultain[2] makes an attempt to explain the therapeutic effect of the drug. Cramer showed that it acts on the afferent nerve ending of the vagus and produces reflexly a slowing of the respiration and a slight fall of blood pressure, due to vaso-dilation. Haultain has given it in 38 consecutive cases, and has lost two mothers, one from pneumonia and the second from septic peritonitis. In his patients he noted that veratrone caused a precipitant fall of blood pressure. The fall is stated to have varied between 40 and 60 mm. of mercury. In healthy rabbits and cats the drug produces but a slight fall of blood pressure, but when the pressure is raised by injection of an extract of chorionic villi and syncytium from an eclamptic subject it causes a marked fall. He suggests that the vagal action of the drug does not account for the drop in eclampsia cases. He also points out that the eclamptic patient tolerates larger doses of the drug than do persons suffering from uræmia and much larger doses than do normal persons. He explains the action as follows: Eclampsia is caused by a toxin contained in the chorionic villi and syncytium passing into the blood stream and giving rise to an increase of the fibrinogen and fibrin ferment content of the blood. This is supposed to be due to a decrease in the production of antithrombin by the liver. The blood, in consequence, tends to coagulate or to become more viscid. Veratrone is said to lower blood pressure in eclampsia, and Haultain suggests that this must be effected in one of three ways. The formation of toxins by the chorionic villi may be prevented, or the formed toxins may be neutralized in the blood, or it may act on the liver, stimulating it to produce antithrombin. The details of the cases published do not offer any confirmation of these views. They show that the eclamptic seizures ceased after the administration of the drug, and simultaneously the blood pressure fell. It is not impossible that the reduction of the blood pressure is a secondary effect. The author points out that the albumin content of the urine is diminished by the drug; but from his records it appears that the actual amount of albumin excreted in the twenty-four hours did not diminish regularly after the drug had been given in his cases. At times it increased materially. The amount of urine increased after the fits stopped, and it may be asked whether the veratrone stopped the fits or increased the amount of urine excreted. The author has raised a very important question in the therapeutics of eclampsia, and it would be well if this matter were investigated. His speculations as to the action of the drug does not solve the problem, and if the drug really cures eclampsia, as he suggests it does, a proper understanding of the action is essential for its most advantageous use.

[1] *Lancet*, December 9, 1915.
[2] *Edinburgh Medical Journal*, December, 1916.

SECOND CONSIDERATIONS.

In our issue of December 23, 1917, we pointed out that the Legislative Assembly of Queensland had approved of a Bill to register opticians, and that the onus of accepting or refusing this measure rested with the Legislative Council. The Council of the Queensland Branch of the British Medical Association brought to the notice of the members of the upper chamber the reasons for opposing the measure. The Bill has been brought up at the Legislative Council recently, and on the motion that the Bill be now read a second time the Honourable C. F. Marks suggested that the word "now" be replaced by the words "this day six months." He dealt with some of the anomalies of the Bill, and emphasized the impossibility of forming a board representative of competent opticians in the State. In opposing this motion the Honourable T. M. Hall used a curious argument. Their duty was to prevent an injustice or injury being done to the public by allowing

people to practice as opticians who did not possess the necessary qualifications required before registration. Later on in the debate the Secretary for Mines read a list of questions comprising the examination for the membership of the Institute of Ophthalmic Opticians of Queensland. The questions were ordinary questions in optics, and did not include one bearing on the diseases or defects of the human or animal eye. It is a little difficult to understand how the public would be exposed to danger if recognition of persons who had gained some slight knowledge of optics were withheld in connexion with the prescribing of glasses for visual or ocular abnormalities. Another argument in favour of the Bill was that some persons could not afford to go to an ophthalmic surgeon. To give the public the impression that spectacle makers possess sufficient knowledge to enable them to prescribe spectacles does not seem to us a means of economy, seeing that irreparable harm may be done if a disease with eye symptoms is not recognized and if improper treatment is applied. Dr. Eleanor Bourne, the Chief Medical Inspector of Schools of Queensland, gives some direct evidence in her annual report for 1915 of injury inflicted by erroneously applied spectacles by opticians in the State. The members desired to listen to the opinion of the Presiding Chairman, the Honourable W. F. Taylor, M.D., and our able colleague, speaking from the side of the dais, delivered a speech which convinced the majority of those present that it would be unwise to grant registration to opticians. The Bill was therefore deferred for six months, and for the present the community of Queensland have been spared a grave danger.

Hospitals.

BROKEN HILL AND DISTRICT HOSPITAL.

The annual report of the Broken Hill and District Hospital for the year 1916 contains a short summary of the work undertaken during the year, and of the financial position of the institution. The Board of Management share with other hospital boards an uncomfortable sensation of watching their expenditure increase and their income decrease. They were placed at a disadvantage in another direction, in that the Surgeon-Superintendent, Dr. M. Birks, was compelled to work single-handed for a period of eight months. Towards the end of the year, as a result of representations made to the military authority, some of the medical officers were detailed for duty at the hospital.

The number of patients dealt with during the course of the year was 1,293. Of these, 105 were still under treatment at the end of the year. There were 131 deaths, and 1,051 patients were discharged. The mortality works out at 11.03%. Eighteen of the 131 patients died within one day of admission. Over 500 patients were treated for infective diseases. There has been an outbreak of diphtheria in Broken Hill almost continuously since March, 1913. During the 3¾ years, no less than 1,093 patients suffering from this disease have been treated in the hospital. There were 329 cases in 1916 and 14 deaths. The case mortality is therefore 4.25%. If those patients who died within 24 hours of admission be omitted, the death-rate would be reduced to 2.73%. No less than 100 patients were admitted on account of enteric fever. There were 17 deaths. There were 51 patients under treatment for lobar pneumonia, with 11 deaths, 15 for cerebro-spinal meningitis, with six deaths, and 10 for scarlatina, without any deaths. Of the 51 patients with pneumonia, 27 were miners working underground, and eight were employed on mines overground. The fatal cases were limited to those working underground. There were 19 cases of tuberculosis, with six deaths. During the course of the year 380 operations were performed, including a large number of major operations.

In July, 1916, His Excellency the Governor of New South Wales visited Broken Hill and laid the foundation-stone of a sanatorium for consumptives within the grounds of the hospital. We are informed that the building, which is now in the course of erection, has been planned on up-to-date lines.

At the beginning of the year the Honorary Treasury was faced with a deficit of £1,516. The expenditure for the year amounted to £17,708, including a transfer to the Ambulance Trust, and payments for additions and repairs to buildings. The income from subscriptions, donations, bequests, etc., amounted to £2,142, that from the Workers' Contribution Fund to £3,423, and that from contributions by patients and from other miscellaneous sources to £1,018. Application was made to the Government for assistance to enable the Board to meet their obligations, with the result that special grants, in addition to the subsidy, aggregating over £13,000, were placed to its credit. The Honorary Treasurer has therefore a small credit balance to start the year 1917 with.

Medical Societies.

(Affiliated with the British Medical Association.)

NORTHERN DISTRICT MEDICAL ASSOCIATION.

The annual meeting of the Northern District Medical Association, New South Wales, was held at Dr. Buckley's house, in Tamworth, on January 24, 1917, Dr. H. L. Harris, the President, in the chair.

The Honorary Treasurer presented his report, which was adopted.

The following members were elected office-bearers and members of the Committee:—

President: Dr. W. E. Harris.

Vice-President: Dr. R. Farrell.

Honorary Secretary and Treasurer:—Dr. E. Buckley.

Members of Committee: Dr. L. Birch, Dr. H. L. Harris, Dr. R. M. Kinross, Dr. A. J. Mackenzie, Dr. T. P. McKell, Dr. B. L. Middleton, Dr. J. A. J. Murray, Dr. E. L. Newman, Dr. A. J. Park, Dr. G. Riolo, Dr. W. Ritchie, Dr. R. Roger, Dr. C. H. Scott, Dr. G. P. Stanley, Dr. F. S. Stuckey, Dr. M. M. Vernon and Dr. F. H. Wrigley.

Honorary Auditor: Dr. J. P. Sexton.

It was moved by Dr. H. L. Harris and seconded by Dr. W. J. McKee that Dr. W. Ritchie be appointed Delegate to attend at the Annual Meeting of Delegates and the quarterly meetings of the Council of the New South Wales Branch. The motion was carried.

It was moved by Dr. J. P. Sexton, seconded by Dr. G. P. Stanley, and resolved, that representations be made to the New South Wales Branch Council protesting against lodge members or their dependents claiming medical benefits while on a temporary visit to the district. It was held that these persons should be treated as private patients.

Communications were received from the Northern Suburbs Medical Association and from the City Medical Association, suggesting that all the members of the New South Wales Branch of the British Medical Association should apply for a commission in the Australian Army Medical Corps Reserve. A discussion took place, and it was decided to recommend all the members of the Northern District Medical Association to apply for a commission in the Reserve.

Dr. Harry Scott was elected a member on the motion of Dr. E. W. Buckley, seconded by Dr. Harris.

Abstracts from Current Medical Literature.

PATHOLOGY.

(59) Cerebro-spinal Fever.

E. C. Hort and A. H. Caulfield (*Journ. Roy. Army Med. Corps*, September, 1916) have continued the search for a filter-passing virus, other than the meningococcus, in the spinal fluid from cases of epidemic cerebro-spinal fever. In all the persons from whom cerebro-spinal fluid was taken for further investigation the meningococcus was isolated from the cerebro-spinal fluid at some time during the course of the illness. The meningococci were identified by the classical biochemical and serological methods. The authors have tested the virulence of these spinal fluids upon monkeys. The fluids have been treated in various ways before injection. Five monkeys were injected with fresh, unfiltered cerebro-spinal fluid, in which no meningococci could be seen with the microscope. Three died, another had continued fever, while the fifth showed no symptoms of illness. In three samples of the fluid used for inoculation, meningococci could be demonstrated by cultivation. Seven monkeys were injected with filtered cerebro-spinal fluid. No meningococci could be found by cultivation of the filtrate. The filters employed were Chamberland F. Meningococci were obtained by cultivation in five of the samples of unfiltered spinal fluid. Three monkeys died and three showed continued fever. Four monkeys were injected with undiluted, unfiltered cerebro-spinal fluids which had been placed in the incubator for at least twenty-four hours before being used for injection. Meningococci could be seen in large numbers in the fluid. They were identified by cultivation. Three monkeys remained well, while one showed continued fever. Four monkeys were injected with filtered cerebro-spinal fluids which were incubated after filtration. Meningococci were cultivated from all the incubated filtrates. No monkey showed any symptoms of illness. Three monkeys were injected with spinal fluids which had been incubated for several weeks. Meningococci were present at the beginning of the incubation, but died out during the incubation. Two of the monkeys died. Two monkeys were injected with the same material after filtration. One died and the other showed continued fever. The doses employed in these injections were quite small when compared with those used in the earlier series. The authors have noted that inoculation of serum broth with cerebro-spinal fluid gave rise to a persistent turbidity. This turbidity was not due to visible organisms. By sub-culture the turbidity could be produced in serum broth. Similar appearances were observed in cultures from the cerebro-spinal fluid of monkeys inoculated with the turbid fluid. These monkeys either died or suffered from continued fever. It has also been noted that some cultures of the meningococcus showed this same turbidity after the broth had been freed from meningococci with the centrifuge. Monkeys injected with these cultures of the meningococcus suffered from continued fever, and four out of seven monkeys died. The cultures were filtered through Chamberland filters, and the filtrate injected into monkeys. The monkeys either died or exhibited continued fever. The authors conclude from these experiments and observations that the cerebro-spinal fluid in epidemic cerebro-spinal fever contains a filter-passing agent which is not the meningococcus but which is capable of producing in monkeys continued fever or death, and that this agent is a living virus which can be cultivated in the laboratory and passed through monkeys. They point out that gross pathological lesions of the meninges are not produced in monkeys injected with cultures of the meningococcus, with filtered or unfiltered cerebro-spinal fluid, or with cultures of the agent passing through a filter.

(60) Weil's Disease.

A. Stokes and J. A. Ryle have shown that the epidemic jaundice occurring in Flanders is due to *Spirochaeta icterohaemorrhagica* (*Journ. Roy. Army Med. Corps*, September, 1916). Weil's disease, which prevails in an epidemic and endemic form, is characterized by conjunctival injection, muscular pains, fever, jaundice, hæmorrhages and albuminuria. It is due to a spirochaete present in the blood. The disease is infectious, though the mode of infection is not known. The authors have seen fifteen cases of this ailment. They have infected two animals from the blood of patients. These animals have shown the characteristic pathological lesions. The spirochaete has been found in the blood of the infected animals. Reinoculation from animal to animal has also been successful. In Flanders the onset of the illness has been sudden, with headache and pains in the lower limbs. The patients become weak, and jaundice developes in a few days. The patients have been admitted to hospital after several days' illness. One was admitted on the fifth day, four on the sixth day and the others a day or two later. The patients all exhibited intense conjunctival injection, jaundice and fever. The stools were, in every case, normal in colour. The blood was examined with the dark field. In one case only have the spirochaetes been seen in the blood. Blood was inoculated into guinea-pigs, which became ill in two cases. In both of these cases the blood was taken on the sixth day of the disease. The guinea-pigs were killed and an autopsy made. The lungs showed the hæmorrhagic spots similar to the wings of a gaudy butterfly. Emulsions of the liver showed numerous living spirochaetes. In stained specimens most of the spirochaetes were straight, with a hook at the end. A few were spiral in form. Attempts to demonstrate the spirochaetes in the urine of patients have been so far unsuccessful.

Y. Ido, R. Hoki, H. Ito and H. Wani have examined active immunization as a prophylactic measure against infection with Weil's disease (*Journ. Exper. Medicine*, November, 1916). Guinea-pigs were inoculated with three injections of pure cultures of *Spirochaeta icterohaemorrhagica* or with emulsions of the liver of infected guinea-pigs. The virulence of the parasites was attenuated by exposure for a week to diluted carbolic acid in an ice-chest. The guinea-pigs were, in most cases, protected against the effects of inoculation with virulent spirochaetes. Although immune bodies can be demonstrated by Pfeiffer's reaction in the blood serum of guinea-pigs infected with virulent spirochaetes, no immune bodies could be found in the blood serum of the immunized guinea-pigs. A horse was immunized in the same way, and immune bodies appeared in the blood serum. Men were immunized with a vaccine ten times as strong as that used for the guinea-pigs. As it was not considered permissible to inject virulent spirochaetes, the blood serum of the immunized men was tested by Pfeiffer's test for immune bodies. These were found to be present, though not in sufficient amount to prevent the death of the inoculated animals. The immunization caused no secondary symptoms in the men. Passive immunity has not been obtained, either with the serum of men or that of guinea-pigs. In the same paper the authors point out that house and ditch rats may contain the infective parasite. They give instances of infection conveyed from rats.

R. Inada, Y. Ito, R. Hoki, H. Ito and H. Wani have treated patients suffering from Weil's disease with serum from convalescent patients or with serum from an immunized horse (*Journ. Exper. Medicine*, November, 1916). Seventeen severe cases, 17 moderately severe cases and one mild case have been treated in different ways with the serum. To determine the results of the treatment attention has been directed to the case-mortality, to the influence of the serum on the spirochaetes circulating in the blood, to the rate of development of antibodies, to the number of spirochaetes found in the organs after death, and to the effects upon the symptoms and progress of the disease. Special weight is attached to the diminution of the spirochaetes in the circulating blood and to the development of antibodies. The mortality of all cases of Weil's disease treated in the clinic at Kyushu has been 30%, while the mortality of the cases treated with serotherapy has been 14%. It must be, however, remembered that many mild cases of the disease are now recognized by examination of the blood for parasites. When 60 c.cm. of serum from an immunized horse is given in suitable

doses, the whole of the parasites in the circulating fluid disappear in 24 hours. With less serum the destruction of spirochaetes is not complete. Antibodies appear in the blood of patients earlier when the patients are given anti-serum than when the serum is not used. The quantity of anti-substance developed by the patient is too variable for the statement of any conclusion as to the effect of serum on the amount of antibody formed. The number of spirochaetes found in the organs in fatal cases is less when serum has been employed in the treatment. As far as the course of the disease is concerned, no statement can as yet be made, though the period during which the urine is infective seems to be diminished.

PÆDIATRICS.

(61) Vaginitis of Infants.

The frequency of vaginitis in infant applicants for admission to hospitals and infant homes is of vital importance to those institutions, owing to the frequency of the spread of the disease and the difficulty of its thorough eradication. In hospitals the disease may disappear, owing to the gradual discharge of the female inmates; but in institutions this is, of course, impossible, and it is only by quarantine, perhaps for years, that all risk of infecting others is prevented. Hess (*Amer. Journ. of Diseases of Children*, October, 1916) considers that vaginitis is of very frequent occurrence in infants reared in poor surroundings, and is not, in the main, an "institution disease." From a study of cases occurring under his care in an infants' home, he finds that (1) post-mortem examinations show that in the sub-acute and chronic cases of vaginitis in infants the cervix is most frequently involved, and that the vagina generally shows no sign of inflammation. Cervicitis would therefore seem to be a more correct term in this connexion than vaginitis. (2) Where numerous pus-cells without bacteria are found in smears made from the cervix an inflammation may be assumed to be present, and in an overwhelming majority of instances the inciting factor will be found to be the gonococcus. Other micro-organisms may, however, be the cause of the inflammatory process, *e.g.*, a streptococcus, as in a case which was studied, both during life and after death. It should be borne in mind that smears taken from new-born infants very frequently contain pus-cells, probably due to the invasion of the vagina by saprophytic bacteria, and that, in the new-born, they should not be considered pathological or as evidence of gonococcal inflammation. (3) Gonorrhœal vaginitis should not be considered as a disease encountered especially in institutions, as it may be found in a considerable proportion of infants living in crowded city tenements. (4) In child-caring institutions the greatest obstacle to limiting and controlling the spread of the disease is the difficulty of recognizing latent cases. It affords, therefore, but one more aspect of the problem of the healthy but dangerous carrier, and of the difficulty of devising methods to prevent contact infection. By means of provocative inoculations of gonococcus vaccine (three doses of 100, 200 and 400 millions respectively at three-day intervals) it was found possible to convert the concealed carrier into an open case, and in this way to discover many cases which had eluded detection. Vaccinations have also some prophylactic value, and may either confer protection or render subsequent infection of a mild character, so that it assumes a bacteriological rather than a clinical type. (5) There is not only a natural susceptibility to this infection and an acquired susceptibility, as occurs in the course of scarlet fever, but a natural immunity, which may be sufficient to protect infants who come in contact with infected patients.

(62) Fruit Juice for Atrophic Infants.

Gladstone (*Practitioner*, November, 1916) found that certain marasmic infants, which failed to react to a carefully regulated diet, consisting of barley water and cane sugar, with cream and protein gradually added, on the exhibition of large quantities of fruit juices frequently recovered and subsequently gained in weight consistently. From a series of cases he found that fruit juice could be taken to the extent of a pint daily by a dyspeptic atrophic infant under one or two years of age with immediate benefit. A carefully selected, pre-digested food, poor in albumin and fat, could then be digested and absorbed with a resulting gain in weight. At first a loss of weight was to be expected; but at the end of the first week the weight was usually regained. Unless the juice was followed by a diet scientifically adapted to a weak digestion, it did no good whatever. The juice probably acted partly on account of its acid reaction, rendering the bowel unsuitable for germs growing in an alkaline medium. It would have a tonic cleansing effect upon the mucous membrane of the digestive tract, and would act as a diuretic, diaphoretic and general alterative. It supplied an attractive drink, enjoyed by all babies, containing 10% of soluble carbohydrate food, removed the irritability and restlessness of the infant, promoted quiet sleep and rendered the digestive organs able to digest and absorb a light diet. When oranges were available, the juice was made of two parts of orange juice to one of apple juice, diluted with one-quarter the quantity of water; the apple juice was obtained by shredding apples on a vegetable grater and expressing the juice by means of a fruit press. Failing oranges, melon and apple juices were used, but the results were less good. Strawberry, cherry, raspberry and banana were taken and enjoyed by the babies, without any bad effects, and probably any fruit juices available would succeed, provided the acid fruits were not used in too large a proportion, and that, when oranges were not in season, sufficient lemon juice was added to the sweeter juices to supply the necessary acidity.

(63) Tests for Syphilis.

In order to test the comparative value of the luetin (Noguchi) and Wassermann reactions in infancy and childhood De Buys and Lauford (*Amer. Journ. of Diseases of Children*, October, 1916) studied cases from 74 families, including eight children aged from twelve days to under puberty, 63 mothers and eight fathers. Their conclusions are as follows: (1) The Wassermann reaction is not as valuable as the luetin test in cases of hereditary syphilis. (2) The series show that it is impossible for a mother to give birth to a child whose serum gives positive laboratory tests for congenital syphilis without her own serum giving positive tests. (3) While they believe that the luetin test is of more value, in being more often positive than the Wassermann reaction, they do not consider that it should replace the latter, as both tests, it would seem, serve distinct purposes. The Wassermann reaction yields evidence of the presence of antibodies in the circulation, indicating an active process, while the luetin test not only gives this evidence, but indicates an existing syphilitic condition, even though it be inactive. (4) The luetin test is not without its disadvantages, as it requires considerable experience in differentiating the lesion from that produced by the intradermal injection of sterile, inert, foreign material. It is also influenced by the administration of certain drugs, which may give rise to a pseudo-reaction, thereby adding to the possible inaccuracy in the interpretation of its reading. (5) Luetin reactions should not be considered negative until sufficient time shall have elapsed (up to 24 days) to warrant such a reading.

(64) Pneumonia in Childhood.

From a detailed study of 32 cases (387 observations made) of pneumonia in children of from two to ten years, the disease being very severe in three, severe in fourteen, moderately severe in four, mild in three and fatal in eight, Morse and Hassmann (*Amer. Journ. of Diseases of Children*, November, 1916) conclude that (1) there is no constant relation between the systolic, the diastolic or the pulse pressure and the severity of the pneumonia or the temperature of the surrounding air; (2) the rates of both the pulse and respiration show a tendency to vary directly with the temperature of the surrounding air; (3) the patients symptomatically seem more comfortable when they are out of doors than when in the house; and (4) no conclusions are justified as to the effects of the cold-air treatment on the mortality of pneumonia in childhood.

British Medical Association News.

MEDICO-POLITICAL.

A meeting of the Council of the South Australian Branch was held on February 9, 1917, for the purpose of considering the steps that should be taken to safeguard the interests of medical practitioners serving in the Australian Army Medical Corps. The following resolution was adopted, and will be submitted to the consideration of the members at the next monthly meeting of the Branch:—

> Members are informed that the disposition of medical men in the army at home (*i.e.*, South Australia) is arranged by the District Medical War Committee, on which the Council of this Branch is strongly represented. In order that the most effective control may be obtained and to avoid hardship, members are invited to inform the Council of any changes in practices which may be contemplated.

The Council of the Victorian Branch has requested us to make the following statement in order that the true position of the relations between the Victorian Branch and the Association of Friendly Societies at the present time may be clearly defined.

On June 15, 1914, a conference was held between 19 representatives of the Friendly Societies and an equal number of representatives of the Victorian Branch. At this conference a committee of ten was appointed to consider the matter in dispute and to report its findings to the full conference. The committee met on August 8, 1914, but as war had been declared in the meantime the following resolution was carried:—*

> That in this national emergency a recommendation be sent to the Councils of the British Medical Association (Victorian Branch) and of the Association of Friendly Societies in Victoria to postpone the consideration of the matters now under consideration to some future date.

The words "to some future date" and not "until the end of the war" were used advisedly, so that the resumption of the deliberations of the committee of ten should not be held up indefinitely. It was agreed on both sides that nothing should be done in the meanwhile to affect the *status quo*, and Mr. Stanton Crouch and Mr. Knight, the Secretaries of the two Associations, were authorized to confer at some future date for the purpose of convening a further meeting. The committee of ten has thus reserved to itself the right of reopening negotiations at any time held to be advisable.

The annual meeting of the Ballaarat Division of the Victorian Branch was held in the Board Room of the Ballaarat District Hospital on February 8, 1917, Dr. E. Champion, the Vice-President, in the chair.

After the minutes of the last annual meeting had been read and confirmed the meeting adjourned, on the motion of Dr. Robert Scott, for ten minutes, out of respect to the late Dr. M. F. Kelly, who had been President of the Division during the year 1916.

The annual report and balance sheet were received and adopted.

On the motion of Dr. W. Sloss it was determined that the rebates on members' subscriptions due to the Division from the Victorian Branch should not be applied for during the continuation of the war.

The following members were elected office-bearers and members of the Council for the ensuing year:—

President: Dr. E. Champion.
Vice-President: Dr. W. A. Spring.
Honorary Treasurer: Dr. Robert Scott.
Honorary Secretary: Dr. A. C. H. Salter.
Members of Council: Dr. W. Sloss, Dr. A. G. McGowan and Dr. P. H. Liddle.
Branch Representative: Dr. E. Champion.
Honorary Auditors: Messrs. F. Herbert and A. A. Macleod.

*See *The Medical Journal of Australia*, August 8, 1914, p. 138, and August 22, 1914, p. 192.

On taking the chair Dr. Champion thanked the members for having elected him President of the Division, and then introduced Captain E. T. C. Milligan, who had accepted an invitation of the Division to address the members on the subject of his experiences in the war zone. This paper will be published in a subsequent issue of the *Journal*.

Drs. T. H. Donnelley and A. H. Barrett were elected members of the Ballaarat Division.

The Minister of Public Health of New South Wales invited the Council of the New South Wales Branch of the British Medical Association to appoint representatives to discuss with him certain matters in connexion with the policy of his Department. A conference was held on February 12, 1917. The representatives of the New South Wales Branch were Dr. Sinclair Gillies (President), Dr. R. Gordon Craig (Vice-President), Dr. F. Antill Pockley (Chairman of the Medical Politics Committee), and Dr. R. H. Todd (Honorary Secretary).

The following gentleman has been nominated for election to the New South Wales Branch:—

Dr. Robert Augustin Gardner, Royal Alexander Hospital for Children, Camperdown.

CONFERENCE OF MEDICAL PRACTITIONERS AND PHARMACISTS.

Schedule of Drugs under Venereal Diseases Act, 1916.

By direction of the Minister of Public Health (Hon. D. McLeod, M.L.A.) a joint conference of medical practitioners and pharmacists was held at the College of Pharmacy, Melbourne, on January 25, 1917, to recommend a list of drugs and medicines which, under Section 5, sub-section 3 of the "Venereal Diseases Act, 1916," might be sold only on the written prescription of a legally qualified medical practitioner.

The following representatives were present:—

Medical Practitioners: Dr. Allen Robertson, Dr. F. Hobill Cole, Dr. J. H. Johnson, Dr. J. Kennedy, Dr. R. L. McAdam and Dr. Noyes.

Pharmacists: Mr. C. E. Towl, Mr. A. R. Bailey, Major D. A. Cossar, Mr. F. Buckhurst, Mr. H. B. Taylor and Mr. F. W. White.

Mr. W. A. Callaway, Under Secretary for Victoria, presided.

Dr. Cole moved and Dr. McAdam seconded that Mr. C. L. Butchers, Registrar of the Pharmacy Board, act as Secretary to the conference. The motion was carried.

The Chairman said that when the Act was originally drafted it contained a clause which practically prohibited the sale of any drugs and medicines which might be used for the treatment of venereal diseases, except on a doctor's order. The chemists thought this was unreasonable, and, as the result of representations which were made to the Minister, an amending clause was drafted and subsequently became a part of the Act. When this clause was being discussed the Minister gave an assurance that a conference of medical men and pharmacists should be held to determine what drugs and medicines should be included in the regulations to be made under Section 5, Sub-section 3 of the Act. This section, in effect, was as follows: First of all there was an absolute prohibition against any person, other than a medical practitioner, prescribing or supplying any drug or medicine to any person suffering from venereal disease.

The sub-section permitted the dispensing of prescriptions under certain conditions, and it exempted registered pharmaceutical chemists from the general prohibition to the following extent. They were permitted to sell or supply any drug or medicine in the ordinary course of their business (except such drugs or medicines as were specified by regulation), provided that these drugs or medicines were not prescribed by the chemist for any person suffering from any venereal disease for the purpose of curing, alleviating or treating such disease. The object of the conference was to specify

those drugs or medicines which were to be regulated and could only be sold on prescription.

Dr. Noyes explained that the medical representatives had been called together rather hurriedly, and had not had an opportunity of discussing the matter beforehand.

Dr. Allen Robertson said that the question had been before the Council of the Victorian Branch of the British Medical Association on several occasions. He thought that the whole crux of the matter was that certain drugs were used for the treatment of venereal disease and for other purposes. The question was whether pharmacists were to be allowed to supply these drugs without restriction.

The Chairman asked whether there were any drugs specifically used for the treatment of venereal disease and for any other purpose.

Dr. Allen Robertson said that there were.

The Chairman said that it might be a simpler procedure if this class of drug was discussed first.

Mr. Towl asked for a ruling of the Chairman whether the section contemplated a schedule of drugs which could not be sold except on prescription, or vice versa, a list of those drugs which could be sold.

The Chairman said he thought that the wording of the section clearly indicated that the regulations were to name those drugs or medicines which could not be sold except on prescription. The section itself provided an additional safeguard inasmuch as those drugs which were not placed on the schedule could not knowingly be sold for the purpose of treating venereal disease.

Mr. Bailey said he felt quite certain that the Chairman was right in his ruling, and that Parliament intended the conference to recommend a "black list."

Dr. McAdam said he thought that if they were to do this the "black list" would have to be most comprehensive.

Mr. Buckhurst said he thought that those drugs which were used for a dual purpose should not be included on any prohibited list.

Dr. Noyes expressed the opinion that if the principal use of certain drugs was in the treatment of venereal disease that should be a sufficient reason to place them on the schedule. There were many drugs which might be easily used for other purposes, but were more particularly used for the treatment of venereal disease.

Dr. McAdam thought it would be a very difficult matter if they had to draw up a list of drugs which might be used for the purpose indicated. They would have to go through the whole Pharmacopœia.

Mr. Buckhurst said that any chemist who sold any article in the "black list" except on a doctor's order was guilty of an offence under the Act. In the second place, if he sold any drug or medicine, even if it were not on the "black list," and he knew that such drug or medicine was for the purpose of treating venereal disease, he was also guilty of an offence. It seemed to him that the views of the medical and pharmaceutical bodies almost coincided. The whole object of the conference was to prevent the treatment of these complaints. Pharmacists desired to work in harmony with medical practitioners in stamping out quackery and similar abuses. They were both imbued with the same motives. At the same time it would not do to be too unreasonable in the drafting of the proposed schedule. He instanced balsam of copaiba as a case in point. This was often used for poultry diseases. If the chemist sold it for that purpose, then clearly he was not liable; but if he knew that the person asking for it intended to use it for a venereal complaint, then there was an offence under the Act. He thought that the best plan was to start with those drugs which both sides agreed should be placed on the list. He personally was quite agreeable that salvarsan and other similar drugs should only be supplied on a doctor's order.

Dr. Noyes thought it would be an advantage if they took each of the diseases mentioned in the Act separately. He thought this would facilitate progress.

The Chairman said that as gonorrhœa was mentioned first under the Act they might deal with it before the other complaints.

Dr. McAdam said that sandal-wood oil and copaiba were used for other things; but the main thing to consider was for what purpose they were most commonly prescribed.

Mr. Towl said he saw a difficulty if they were going to include drugs of this nature in the list. The veterinary people would be almost certain to make a very strong protest if any of the drugs mentioned were included. Copaiba was frequently used in veterinary practice. It had other specific uses, and, in his opinion, was certainly a drug which could be used for other complaints.

Dr. Noyes said that he realized the difficulty of including drugs of this nature. To do so would involve practically all the oleo resins, the astringents, permanganate of potash, catechu and the zinc salts.

Mr. Buckhurst thought the conference would be undertaking an impossible task if it attempted to classify drugs and medicines of this manner. He thought they could only deal with those articles which were exclusively used for the purpose of venereal disease. He was present at Parliament House during the whole of the debate on the Bill. He had no doubt in his mind that Parliament did not intend simple uncompounded drugs of this nature to go on any "black list."

Dr. Allen Robertson said that a man might go into a chemist's shop and ask for a half a crown's worth of sandal-wood oil.

Dr. Noyes: It means you could drive a coach and four through the Act.

Major Cossar: I do not think so. No chemist could sell any of the drugs referred to if he knew they were for treating venereal disease. It would be too great a risk for any chemist to run.

The Chairman said that in dealing with the matter they would have to regard what the intentions of Parliament were. He read several extracts from Hansard, which clearly indicated that the Legislature did not intend the regulations to include simple drugs which had a dual use. The Minister for Health frequently assured the House that this would not be done. At one stage of the debate he specifically mentioned such drugs as sandal-wood oil and cubebs. It was evidently the intention of Parliament that the sale of these drugs should be allowed, provided they were not knowingly sold for the treatment of venereal disease.

Dr. Allen Robertson: That raises the whole question. It is the opinion of the members of the Victorian Branch of the British Medical Association that chemists should be prevented from selling these drugs.

The Chairman: You must look at the intention of the Act. Chemists can sell the drugs for ordinary purposes as long as they do not prescribe them for a venereal patient.

Dr. Noyes: A man goes in and asks for some copaiba. The chemist can supply it, provided he does not know it is to be used for the purpose of treating this complaint.

Major Cossar said that the chemist was just as eager as the medical man to assist in stamping out this disease. He was always sending people to medical men. The quacks were the persons who did the harm. By stopping treatment by unqualified persons a great stride had been made. It would be unwise to go too far with the proposed list. To include copaiba in its simple form would arouse great opposition. In his opinion education would do more good. They were working from the wrong end.

Mr. Towl: We have men in our ranks, black sheep, who must be restricted; but the medical profession have also a similar class of men in their ranks. All the charlatanism is not on the pharmacists' side. I say this with great respect to those present; but we are here to face things as they are. In my opinion, the Act will put an end to chemists treating this disease. That being the case, the list should be reasonable and practicable.

Dr. Cole said that if the "black list" was to be restricted to drugs and preparations specifically used for the treatment of veneral disease, objection would be taken to the inclusion of any drug in the British Pharmacopœia.

Mr. White: Yes.

Mr. Towl said he had obtained a list of proprietary preparations from the various wholesale houses. Arhéol capsules were included in this list. They were frequently prescribed by doctors.

Dr. Kennedy thought it was impossible to place simple drugs on the list. If that were done, they would have to

include such things as sulphate of zinc and permanganate of potash.

Mr. Buckhurst considered that because there were a few chemists who stooped to certain practices they must not penalize all pharmacists. He was afraid that if they included simple drugs there would be strong opposition. In his opinion this would be justified in view of the promises given when the Bill was before Parliament.

The Chairman suggested that a start might be made with proprietary preparations.

Dr. Noyes said that on this point both sides could agree.

Major Cossar said that if proprietaries were included it would lead to good results.

The Chairman said that they might adopt a general prohibition applying to all classes of venereal disease as defined by the Act.

Dr. Noyes agreed that this would save time. He was quite willing to deal with the matter in this way, in view of the limitations under which the conference laboured.

Mr. Buckhurst pointed out that it must not be overlooked that postal business was not affected by the Act. Any person could get any of the prescribed articles by writing to someone in another State. Now that the general aspect had been fully discussed, he moved as item one on the proposed schedule:—

> All patent and proprietary medicines which are specifically recommended for the cure, alleviation or treatment of venereal disease.

This was seconded by Mr. Towl and carried unanimously.

It was moved by Mr. Bailey, seconded by Dr. Kennedy, and resolved:—

> That kharsivan and all similar synthetic organic arsenic compounds be included in the schedule.

It was moved by Dr. Noyes, seconded by Mr. Buckhurst, and resolved:—

> That gonococcus vaccines and serums and gonorrhœal phylacogen be included in the schedule.

It was moved by Dr. Kennedy, seconded by Major Cossar, and resolved:—

> That all medicated bougies be included.

It was moved by Mr. Towl, seconded by Dr. Noyes, and resolved:—

> That argyrol and all other similar synthetic organic silver compounds be added.

Dr. McAdam asked whether mercurials should not be included.

Mr. Bailey said that this would involve great difficulty, as mercurials were widely used for other purposes than venereal diseases.

The Chairman asked if there were any other further recommendations or suggestions.

Mr. Towl said that both wholesale druggists and retail pharmacists had considerable stocks of goods which would be on the "black list." They had asked that reasonable time should be given them to dispose of these articles, which they had been selling uninterruptedly for many years. In some cases the stocks would last over six months.

Dr. Kennedy said he was opposed to any time limit. It would pay the State to buy the goods and destroy them.

Dr. Noyes thought the conference should not recommend any concession in this direction. The wholesale houses were well able to look after themselves.

The Chairman said that it would be several weeks at least before the regulations were gazetted. They had to be sent to every member of Parliament, and it was quite possible that some of them might be objected to, and thus cause further delay.

Dr. McAdam moved that the conference adjourn to Thursday, February 1, 1917.

Mr. Buckhurst seconded the motion, which was carried.

Dr. Noyes proposed a vote of thanks to Mr. Callaway for so ably presiding at the meeting. They were fortunate in securing Mr. Callaway as Chairman.

Mr. Towl said he desired to second the motion. The conference was greatly indebted to Mr. Callaway for his kindness in acceding to the request to preside over the deliberations. The motion was carried with acclamation.

Mr. Callaway, in responding, said that if he had been of any service he was satisfied. They were all servants of the public, and the welfare of the people must be their first consideration.

The conference then adjourned.

The adjourned meeting was held on February 1, 1917.

Mr. Callaway presided, and there were present Drs. Noyes, McAdam, Johnson, Kennedy and Allen Robertson, Major Cossar, and Messrs. Towl, Buckhurst, Gulliver and Taylor.

The Chairman said that he had shown the resolutions carried at the last meeting to Dr. E. Robertson, Chairman of the Board of Health. Dr. E. Robertson had asked whether ferrovine would be covered by the resolutions.

Mr. Towl said that it would come under Regulation 1. It was very little used.

The Secretary said that Dr. E. Robertson suggested the inclusion of antimonial preparations.

Dr. McAdam thought that antimony might be placed on the list.

Mr. Gulliver protested. He said that pharmacists could hardly be expected to agree to such a proposal. The drug was used for so many purposes.

Major Cossar said that tartar of antimony was frequently used for destroying ants. It was also used in worm powders for horses.

Mr. Buckhurst said that he would not object so much to antimony prepared for hypodermic injections going on the list, but he could not accept the responsibility if other preparations of antimony were included.

Major Cossar: Is it worth considering? No chemist would sell it for hypodermic use.

Dr. Allen Robertson said that he thought there should be a general inclusion of all drugs used in the treatment of syphilis if the seller knew they were to be used for that purpose.

Mr. Buckhurst said that the Act provided for that.

Dr. McAdam asked if the conference's recommendations would be subject to review. He understood a departmental board was dealing with the general regulations under the Act. He thought if any amendments were made, they should be considered by the conference before being finally adopted.

Dr. Noyes agreed that the conference should be consulted before amendments were sanctioned.

The Chairman said he had spoken to the Minister, and had informed him of the suggestion made that the conference thought its recommendations should be accepted in the form adopted. Mr. McLeod had stated that he had no intention of referring the recommendations of the conference to any other body. He did not think the departmental committee appointed to consider the regulations generally had any authority to interfere with the conference's recommendations.

Dr. McAdam: I want to be quite assured on that point.

The Chairman: I think you may be quite assured. It would not be a proper thing to review the decisions of the conference, which has been convened by the Minister for a specific purpose.

(No further action was taken regarding the proposed inclusion of ferrovine and antimonial preparations.)

Dr. Allen Robertson: How are you going to deal with iodide of mercury?

Dr. McAdam: We should include the salts and other preparations of mercury used in the treatment of venereal disease.

Major Cossar: Calomel is very widely used for other purposes, and so is black wash.

Mr. Towl: How could you deal with this class of drug?

Dr. McAdam: The only way is to throw the onus on the chemist.

Mr. Buckhurst: It is on him already under the Act itself.

Dr. Allen Robertson: The chemist should satisfy himself of the purpose a drug is to be used for.

Mr. Buckhurst: How can he? Is he to ask every customer what he wants a mercurial preparation for? It could not be done.

Major Cossar: Medical men increased the sale of specifics and nostrums by prescribing them frequently. The "tabloid habit" was induced by patients seeing it written in prescriptions.

Mr. Buckhurst: A large proportion of the prescriptions coming into my pharmacy contain one or more proprietary medicines. Is it fair to the chemist?

Dr. Allen Robertson: I do not think there is much of this class of prescribing.

Mr. Towl: It is surprising how much of it there is.

The Chairman: The discussion is digressing somewhat.

Mr. Towl: I was about to observe that you must trust to the pharmacist's sense of honour that the spirit of the Act will be observed. Pharmacists are just as anxious as medical men to stamp out venereal diseases. They do not all look at it from the financial view, although that has to be considered. The main thing is the public good. But it must not be overlooked that there are so many drugs in general household use which might be used for venereal treatment. Such drugs certainly should not be included.

Dr. Noyes: We recognize that. We do not wish to make the road too hard.

Mr. Buckhurst: The pharmacist is willing to assist; but you cannot expect him to make unnecessary sacrifices. If the conference is reasonable it will find pharmacists doing all they can to help the medical men stamp out the disease.

Dr. McAdam: How are they going to help if they do not know a patient is suffering from the disease.

Mr. Buckhurst: Because the pharmacist enjoys the confidence of his customers. Great good can be done if pharmacists are placed on their honour. You must not try to do everything at once. This conference will probably be called together again. Experience will have shown by then whether we have gone too far or not far enough.

Dr. Noyes: The patient will not confide to the chemist when he knows the sword of Damocles is hanging over his head.

Dr. McAdam: There will be an increasing number of individuals who will hide the disease and go to a quack.

Mr. Towl: We are here to stop quackery. They will soon stop that if there are a few prosecutions.

Mr. Gulliver: If you make these regulations too stringent you will drive men to quackery, and, despite all you do, they will run the risk of prosecution.

Dr. McAdam: I see great difficulty in carrying out the Act.

Mr. Towl: The only way is for medical men and pharmacists to work together on common lines.

Mr. Gulliver: Reform will come gradually. Patients will go to medical men; but not at first.

The Chairman: It is the intention of the Department to send a circular to every pharmacist, pointing out his responsibilities under the Act. The policy to be adopted is to enforce the Act gradually at the start.

Dr. McAdam said he desired to return to the subject of including mercurial preparations and salts.

Mr. Towl: Is it necessary to legislate for every case?

Mr. Gulliver: Surely it is not suggested that such things as calomel and white precipitate be included!

Dr. Kennedy: They are very largely used in venereal complaints.

Major Cossar: I think it is going too far. We might include grey oil, which is specifically used for other purposes.

Dr. McAdam moved and Major Cossar seconded:—

> That grey oil and all similar mercurial emulsions specifically prepared for the cure, alleviation or treatment of venereal disease be included in the schedule.

The motion was carried.

Mr. Towl drew attention to the provisions of the "Poisons Act," which required certain poisons to be signed for and the sale witnessed. In the entry in the Poisons Book the purpose for which the poison was required must be set out.

Dr. Allen Robertson asked for the inclusion of *lotio hydrargyri*.

Mr. Gulliver said black wash was used for other purposes.

Dr. McAdam mentioned mercuric iodide.

Mr. Buckhurst said the latter was frequently used for eye lotions and horse blisters.

Dr. Kennedy suggested *liquor hydrargyri perchloridi* (B.P.).

Mr. Buckhurst: I sold a gallon of it to-day for painting the boards of a house infected with white ants.

Mr. Towl: It is often used for painting bedsteads.

Mr. Buckhurst: I sell a lot of it for the purpose of destroying hair nits.

Dr. McAdam: I still think all mercurial preparations should go on.

The Chairman: I do think a drug like *hydrargyri perchloridum* should go on the list.

Mr. Gulliver said that he feared the schedule would break down if too many restrictions were imposed. They should go slowly at first. Any abuses could be remedied later on.

Dr. Kennedy: *Pilula hydrargyri* is frequently used for venereal troubles.

Dr. McAdam: What is easier for a man than to get some mercury and make a pill himself?

Mr. Buckhurst: You could not stop the sale of mercury. It would stop all mining industries.

Dr. McAdam: Then we come to *hydrargyrum cum cretâ*.

Mr. Buckhurst: Grey powder has been used from time immemorial as a cathartic for children.

Dr. Noyes: I was going to mention that myself.

Major Cossar said if a man came in for 100 chalk and mercury pills he would not supply them.

Dr. Noyes: Burroughs Wellcome & Company and Parke, Davis & Company put up these pills, and they are all sold extensively.

Mr. Gulliver: That class of business is most annoying to pharmacists. It has been largely developed because doctors tell patients to get these pills.

Major Cossar: The aspirin habit is an illustration of how a proprietary drug can be popularized by medical men prescribing it.

Mr. Gulliver: The art of prescription writing has declined.

Mr. Buckhurst instanced two or three cases of this class of prescribing. He would welcome an earnest effort on the part of medical men to limit it. What he said he said in good faith, with due respect to those present. There might be a few pharmacists who stooped to low practices; but they must not condemn all because of the few. Medical men likewise had to deal with a certain class of practitioners. The Act was going to be abused by these so-called specialists.

Dr. McAdam: We cannot deal with them, as there is no power to remove their names from the Register.

Mr. Towl: We have limited powers over pharmacists.

Mr. Buckhurst: If pharmacists do their part they will expect medical men to do their utmost to stamp out charlatanism in their own ranks.

Dr. Noyes: I think you can rely on that being done.

Mr. Buckhurst: We are here to do our utmost to assist the Government in administering this Act. Putting grey powder on the schedule will not help. Pharmacists would feel they were being most unfairly treated.

Dr. Kennedy: *Hydrargyrum cum cretâ* should go on.

Mr. Buckhurst: I would accept the inclusion of the drug in pill and tablet form. That is as far as I could go.

Dr. McAdam: You would not include the powders? That is preposterous!

Mr. Buckhurst: I am only stating my opinion. I think we have met the medical men fairly.

Dr. Kennedy: Blue ointment! I would like to see it on.

Mr. Buckhurst: It would be a very serious thing to put this ointment on the list. If a man deliberately makes up his mind to break the law this schedule will not stop him.

Dr. Noyes: Would you agree to biniodide of mercury?

Mr. Towl: Yes. We would also accept the tannate of mercury and cyanide of mercury.

Dr. McAdam moved and Mr. Towl seconded:—

> That *hydrargyrum cum cretâ* (and its admixtures), biniodide of mercury, tannate of mercury and cyanide of mercury in the form of pills and tablets be added to the schedule.

The motion was carried.

Dr. Kennedy: Potassium iodide! What can we do about that?

Mr. Buckhurst: We could not include it. It is so commonly used as a blood mixture.

Dr. Noyes: I see a difficulty with the iodides. They are used for so many purposes. Is there some way in which we could prevent them being taken for the later stages of syphilis?

Mr. Towl: I do not think that is so important as prevention in the earlier stages. They would be in the doc-

tors' hands before they reached the iodide stage, if I might put it that way.

Dr. Noyes: That disposes of the question of mercury and the iodides. There is now the question of the oleo-resins and oleo-balsalms, including sandal-wood oil, which is seldom prescribed for anything except gonorrhœa.

Mr. Towl: Medical men use it for their sphygmomanometers.

Mr. Buckhurst: I must certainly protest against the inclusion of sandal-wood oil, because it is frequently used for other purposes. I know of medical men who take it themselves for bronchial troubles. It is largely used for the purpose of perfuming soap. Many people who make their own soap purchase it from me. If you include it I know chemists will protest strongly. The Minister for Health agreed that it should not go on. He informed Parliament to this effect. With all due respect I must differ from the medical representatives on this point. The spirit of the Act must be observed. To go too far will be to invite objection. We may make our work abortive if we include it.

Dr. Allen Robertson: Can you guarantee that what we have put on the schedule so far will be accepted?

Mr. Buckhurst: I think no one will object to what we have done so far. The Association I represent will, I feel sure, resent the inclusion of sandal-wood oil. Pharmacists would be justified in asking members of Parliament to object to the regulations if it is included.

Mr. Gulliver: My feeling is we should stop where we are. If abuses arise they can be remedied later.

The Chairman said that the Minister of Health would not be moved by outside representations. He would abide by the conference's recommendations.

Mr. Buckhurst: Except that it could be pointed out that he specifically referred to sandal-wood oil in his statement in the House.

Dr. Allen Robertson: It is important that we should deal with the oleo-resins.

Dr. Johnson: The sale of sandal-wood oil and copaiba in capsules and emulsions should be restricted.

Mr. Buckhurst: I must object to these drugs being included.

Dr. Noyes: If we allow the free oil, could we restrict the capsules and emulsions?

Mr. Buckhurst: What about the veterinary people? I do not mind the mixtures so much, but the drug can only readily be given otherwise in the form of capsules. We are treading on thin ice. I cannot do more than voice my protest.

Dr. Johnson: I do not think either of these drugs are used very frequently for other purposes. We should not leave a loop-hole.

Dr. McAdam: We must look at the main purpose for which the drug is used.

Major Cossar: The Act itself prevents a chemist from selling it for venereal purposes.

Dr. Allen Robertson: The admixtures might be dealt with.

Mr. Buckhurst: I am sorry; but I cannot agree.

Dr. Noyes moved and Mr. Towl seconded:—

> That sandal-wood oil and its derivatives and copaiba and its derivatives in the form of emulsions or capsules be added to the schedule.

Mr. Buckhurst: I cannot guarantee that pharmacists will not protest against this. It is going further than the Minister intended. I think we have shown every consideration to the suggestions made by our medical friends.

Dr. McAdam: Every pharmacist may not be as conscientious as you gentlemen. You represent the cream of the profession.

Mr. Buckhurst: I acknowledge the compliment and reciprocate it; but I must think of those I represent.

The motion was carried.

Dr. Noyes: What about cubebs?

Mr. Buckhurst: It is used for coughs.

Mr. Towl: It ought not to go in.

Major Cossar: The Minister mentioned it as one that should not be included.

Dr. Noyes: Then methylene blue?

Major Cossar: It is used for dyes; but I do not think there would be much harm in including it.

It was moved by Dr. McAdam, seconded by Major Cossar and resolved:—

> That methylene blue in the form of pills, tablets or capsules be added to the schedule.

Dr. McAdam: Formaldehyde and its preparations?

Major Cossar: No.

Mr. Towl: They are used for so many purposes.

Dr. Allen Robertson: Corrosive sublimate.

Mr. Buckhurst: It would be ridiculous to include it.

Dr. Allen Robertson: What about salts used for injections?

Mr. Towl: You could hardly include them. You have our good will; but we must not strain the schedule.

Dr. McAdam: As there are some unprofessional men, so there may be some pharmacists who will try to break this Act. But I think we cannot legislate for every case. I do not think it is practicable to deal with the zinc salts.

The Chairman: Are there any further suggestions?

Dr. McAdam: We have no more suggestions, except that I think that this committee should be empowered to revise the schedule later on if necessary.

Mr. Buckhurst: I think the conference should be properly constituted as a permanent advisory body to the Minister.

Dr. Noyes: I agree with the suggestion. The medical and pharmaceutical bodies acting in harmony could do much to assist the Minister in carrying out the Act.

The Chairman: It is quite competent for the conference to make a recommendation to the Minister.

Dr. McAdam moved and Mr. Buckhurst seconded:—

> That the conference recommends the passing of a Regulation under the Venereal Diseases Act empowering the Governor-in-Council, on the recommendation of the conference, from time to time to add or vary the list of drugs specified in the schedule.

The motion was carried.

It was moved by Mr. Towl, seconded by Dr. McAdam, and resolved:—

> That the Secretary be asked to forward a typed copy of the resolutions to the Minister and to each member of the conference.

It was moved by Dr. Noyes, seconded by Mr. Buckhurst, and resolved:—

> That a copy of the minutes be forwarded to the Secretary of the British Medical Association (Victorian Branch), with a suggestion that they be forwarded for publication to the Editor of *The Medical Journal of Australia*, and that the *Pharmaceutical Journal* be also asked to publish a report of the proceedings.

Dr. McAdam moved and Mr. Towl seconded a hearty vote of thanks to the Chairman.

Mr. Callaway said it had been a pleasure to preside over the deliberations of the conference. He was very pleased to see that there had been such harmony and such unanimity, and hoped that good results would follow what had been done. He trusted that medical men and pharmacists generally would assist their leaders in their praiseworthy efforts to stamp out this disease.

Dr. Noyes moved a vote of thanks to the Secretary. He complimented Mr. Butchers on the praiseworthy manner in which he had carried out his duties, particularly in regard to the preparation of the minutes of the conference, which were concise, clear and accurate.

Mr. Buckhurst seconded the motion.

Mr. Butchers said that he had done his best. He had been a silent observer of the proceedings, but had followed them with great interest. He hoped the medical representatives would assist the pharmacists in stamping out quackery, and that the results of the conference would bring about joint action to attain this end.

After light refreshments had been partaken of, Dr. Noyes proposed a vote of thanks to the pharmacists for their generous hospitality.

Mr. Towl responded. He had always endeavoured to advance the interests of true pharmacy, and he hoped their medical friends would appreciate the spirit which had actuated pharmacists all along in connexion with this Act. If both bodies worked together he felt sure it would react to the benefit of both.

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending February 10, 1917:—

	Metropolitan Combined District.		Hunter River Combined District.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Enteric Fever ..	20	0	1	0	40	2	61	2
Scarlatina	18	1	1	0	24	1	43	2
Diphtheria	43	3	10	0	35	1	88	4
C'bro-Sp'l Menin.	1	0	0	0	2	0	3	0
*Pul. Tuberculosis	19	12	1	0	0	1	20	13
Malaria	2	0	0	0	0	0	2	0

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending February 11, 1917:—

	Metropolitan.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	40	1	24	1	64	2
Scarlatina	13	1	14	0	27	1
Enteric Fever	6	0	16	0	22	0
Pulmonary Tuberculosis	24	4	18	4	42	8
C'bro-Spinal Meningitis	1	—	4	—	5	—

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending February 10, 1917:—

Disease.	No. of Cases.
Enteric Fever	19
*Diphtheria	34
Pulmonary Tuberculosis	10
Scarlatina	7
Erysipelas	2
Malaria	1

* One case returned as membranous croup.

Vital Statistics.

SYDNEY AND NEWCASTLE.

The report of the Government Statistician on the vital statistics of the metropolis of Sydney and of the Newcastle district for the month of January, 1917, has been published in the *New South Wales Government Gazette* of February 16, 1917.

Sydney.

The number of births registered during the month was 1,877, 939 being of males and 938 of females. The birth-rate, expressed as an annual rate, was 29.46, which compares favourably with the average rate for January of the preceding five years. Of the 1,877 births, 128 were illegitimate, and the illegitimate birth-rate was equivalent to an annual rate of 2.01. Approximately 19% of the births took place in hospitals and other public institutions.

There were 718 deaths registered during the month. In 365 instances the deaths were of females, and in 353 they were of males. The death-rate was equivalent to an annual death-rate of 11.27. The average death-rate in January of the previous five years is given at 10.50, so that the rate for the month under review was 7.3% above the average. There were 148 deaths of infants under one year of age, which is equal to an infantile death-rate of 79 per 1,000 births. Among those who died there were four of 90 or over, the two oldest being 97.

From the table giving the causes of death it appears that there were 106 deaths from diseases of the cardio-vascular system. In 60 there was organic disease of the heart, in 23 cerebral hæmorrhage, in eight atheroma and in seven acute endocarditis. The number of deaths from heart affections was considerably above the average for the past ten years. Among the infective diseases diarrhœa and enteritis was fatal in 108 cases. In 90 of these the sufferer was under two years of age. This figure is considerably higher than that of the deaths from diarrhœa and enteritis recorded in January since the year 1908. Tuberculosis caused 38 deaths, including 19 of tuberculosis of the lungs. The frequency of death in the month of January from pulmonary tuberculosis appears to have diminished in the course of ten years. There were 17 deaths from pneumonia and 13 from broncho-pneumonia. The number of deaths from pneumonia during the month of January has varied between 11 in 1910 and 41 in 1916. The average works out at 24.9. Pertussis caused 12 deaths. In January, 1911, there were 25 deaths from this disease. In January, 1910, there was but one, and in January, 1909, and in 1915, there were two. Simple meningitis was responsible for eight deaths, and epidemic cerebro-spinal meningitis for six. There were seven deaths from syphilis, six from diphtheria, five from enteric fever, three from morbilli, two each from influenza and erysipelas, and one each from scarlatina, simple septicæmia, tetanus and acute rheumatism. There were 76 deaths recorded from cancer, which is the largest number for January during the past ten years, the average being 52.6. There were ten deaths from diabetes, four from exophthalmic goitre, and one from leucæmia. Bright's disease proved fatal 38 times and acute nephritis three times. Of the 14 deaths associated with the puerperal condition, two resulted from illegal operations, three were caused by septicæmia, three were said to be due to puerperal albuminuria and convulsions, and two to puerperal *phlegmasia alba dolens*.

Newcastle.

The number of births registered during the month of January in the Newcastle district was 181, and this figure comprises 101 births of males and 80 of females. Seven of the children were illegitimate. The birth-rate, expressed as an annual rate, was 36.94, and the illegitimate birth-rate 1.43. While the birth-rate was higher in January, 1916, it was lower in January of each year since 1908.

The number of deaths registered was 60. In 43 instances the deaths were of males, and in 17 they were of females. The death-rate works out at 12.24 per 1,000 of population. In 13 instances the deaths affected infants under one year of age, and consequently the infantile mortality was 72 per 1,000 births. In January, 1916, it was 98; in January, 1911, it was 97; and in January, 1908, it was 107. It has not been below 72 in January during the past ten years.

The cause of death in 17 instances was associated with affections of the cardio-vascular system, including nine due to organic diseases of the heart and five to cerebral hæmorrhage. There were 13 deaths from diarrhœa and enteritis, infants under two years of age being attacked nine times. There were three deaths from pulmonary tuberculosis, three from pneumonia, and one each from pertussis, influenza, simple meningitis, cerebro-spinal meningitis, acute bronchitis and septicæmia.

TASMANIA.

The Government Statistician's report on the vital statistics of Hobart and Launceston and of the country districts of Tasmania for the month of December, 1916, is now available.

Hobart and Launceston.

The number of births registered in the registration districts of Hobart and Launceston in the month, exclusive of those registered in accordance with the Legitimation Act and the Births Amendment Act, was 148. This number is smaller than the number of births registered in the corresponding month of previous years. The birth-rate is equivalent to an annual birth-rate of 34.20. The birth-rate in Hobart is slightly higher than that in Launceston, the equivalent figures being 35.83 and 31.68.

The number of deaths registered in the two districts was 74. Of these 25 took place in public institutions. The

death-rate expressed as an annual rate was 13.80. In Hobart is was 12.00, and in Launceston 16.44. There has been a material decrease in the number of deaths during December of the past few years. The infantile mortality works out at 6.72 per 1,000 births. Ten of the 74 persons who died were 75 years of age or over.

There were 13 deaths from tuberculosis, seven of which occurred in Hobart and six in Launceston. There was one death from cerebro-spinal meningitis in Hobart and two in Launceston, and one from simple meningitis in each district. Three persons died of pneumonia in the Hobart district and one in the Launceston district. There were two cases of gastro-enteritis in infants under two years of age in Hobart. One death from enteric fever occurred in Hobart. The freedom from fatal cases of the acute infections in both cities is very striking. It appears that during the year 1916 there were four deaths from enteric fever in Hobart and one death in Launceston. In Hobart there were three deaths from diphtheria and nine in Launceston. The death-rate from all causes in the Hobart district during the complete year was 14.73 per 1,000, and that in Launceston district 13.10.

Diseases of the cardio-vascular system caused nine deaths in Hobart and five in Launceston. There were four deaths from Bright's disease in Launceston, but none in Hobart.

Country Districts.

The number of births registered in the country districts of Tasmania during the month of December was 283. The birth-rate was consequently equivalent to an annual rate of 24.84. The birth-rate has declined as compared with that of December, 1914 and 1915. The number of deaths registered during the month was 81, which yields a death-rate equivalent to an annual rate of 7.08 per 1,000 of population. Very little information is published concerning the causes of death in the 81 cases. There were no deaths from enteric fever, three from tuberculosis, but none from pulmonary tuberculosis, three from cancer and one from diabetes.

It appears that the estimated population of Tasmania in 1916 was 201,025, of which 64,499 represented the urban population. The birth-rate for the State for December was equivalent to an annual birth-rate of 28.72. The actual annual birth-rate cannot be calculated from the figures supplied by the Statistician. In regard to the death-rate the figures for the full year are given. While the death-rate in the urban districts was 14.3 per 1,000 of population, the death-rate for the whole State for the year 1916 was 9.59.

University Intelligence.

THE UNIVERSITY OF SYDNEY.

A monthly meeting of the Senate of the University of Sydney was held on February 5, 1917, at University Chambers, Phillip Street, Sydney.

The application of Dr. S. A. Smith, Senior Demonstrator in Anatomy and Acting Tutor in Medicine, for leave of absence for four months from January 18, 1917, was granted.

It was resolved that Dr. J. L. McKelvey be appointed Acting Demonstrator in Anatomy and Dr. J. MacPherson Acting Tutor in Medicine during Dr. Smith's absence.

Letters from Professor Irvine, proposing (*a*) a modification of the diploma course in Economics and Commerce, and (*b*) an extension of the curriculum for the degree of Bachelor of Economics for four years were referred to the Faculty of Arts for report.

A letter was received from Dr. W. N. Benson, resigning the office of Acting Lecturer in Geologoy from February 15, 1917, in consequence of his having been appointed to the chair of geology in the Otago University. The resignation was accepted and the amended arrangements for carrying on the work in the Department of Geology for 1917, as recommended by Acting Professor Cotton, were approved.

A letter from Dr. E. H. Binney resigning the position of lecturer in Tutorial Surgery (Sydney Hospital), and of Demonstrator in Operative Surgery, was received.

The following recommendation passed by the Committee for Tutorial Classes and transmitted by the Director of Tutorial Classes were received and the matter referred to the Faculty of Arts for consideration and report: "This Committee desires respectfully to draw the attention of the Senate to the increasing demand for Social and Political Science in Tutorial Classes, and the need for the provision of University teachers in those subjects."

A discussion took place in regard to candidates for the Leaving Certificate Examination failing to qualify for entrance to the several faculties or departments of the University, and, on the motion of the Dean of the Faculty of Arts, it was resolved: (1) Candidates for the Leaving Certificate Examination who have qualified for matriculation and entrance to any Faculty or Department of the University may be permitted to complete their matriculation qualification for another Faculty or Department if they so desire, by passing in the additional subjects at the forthcoming matriculation examination. (2) Candidates who have passed the Leaving Certificate Examination but who have not qualified for matriculation in any Faculty or Department may be permitted to complete their matriculation examinations by passing in the additional subjects at the forthcoming matriculation examination. (3) Candidates who wish to enter for the Matriculation Examination under these regulations must enter their names at the University on the prescribed form and pay the matriculation fee of £2 not later than Saturday, February 10, 1917.

A letter from Professor Mackie in regard to evening lectureships in Education was referred to the Faculty of Arts.

The degree of Ch. M. was conferred upon Mr. C. Farran Ridge *in absentia*.

Dr. M. C. Lidwill was re-appointed for one year as Tutor in Anæsthetics.

The following examiners were appointed for the matriculation examination:—Mathematics: Mr. H. J. Meldrum, B.Sc. Faculty of Law (Intermediate Examination): The Professor of Law, Dr. G. W. Waddell, Mr. C. A. Weston, B.A., LL.B., and Mr. H. H. Mason, B.A., LL.B. Faculty of Medicine (Fifth Year Examination): Medicine—Dr. A. E. Mills and Dr. A. A. Palmer; Surgery—Dr. F. P. Sandes and Sir Alexander MacCormick; Obstetrics—Dr. Fourness Barrington and Dr. S. H. MacCulloch; Gynæcology—Dr. J. Foreman and Dr. G. Armstrong; Clinical Medicine—Dr. Macdonald Gill, Dr. Sinclair Gillies, Dr. G. E. Rennie and Dr. E. J. Jenkins; Clinical Surgery—Dr. Chas. MacLaurin, Sir H. L. Maitland, Dr. Gordon Craig, Dr. J. Morton and Dr. G. H. Abbott; Medical Jurisprudence and Public Health—Dr. R. H. Todd and Dr. W. G. Armstrong.

On the motion of Mr. Board it was resolved:—

> That the Faculty of Arts be asked to revise the programme of development of University policy, as submitted by the Faculty in 1912, in the light of the demands which the problems created by the war make upon the University; and that other faculties be similarly requested. Also that the proposals of the Faculties be submitted to the Professorial Board, with a view to a recommendation being made to the Senate in regard to the suggestions of the Faculties and other extensions that may be desirable.

Obituary.

JAMES FROUDE FLASHMAN.

Widespread regret was occasioned in Sydney when it was learnt that the supreme sacrifice to the call of duty had been made by Lieutenant-Colonel James Froude-Flashman, M.D., who died at Boulogne, France, on February 12, 1917, rather suddenly, after an attack of pneumonia. Few men of Sydney were better known throughout the State of New South Wales, and many friends in Melbourne and in Europe join in mourning for him, called away in the prime of life.

James Froude Flashman was born at Braidwood, New South Wales, in 1870. His father, who died many years ago, was a well-known man of business in that town. His aged mother and two sisters survive him. He was educated at the Sydney High School. He proceeded to the University of Sydney, and graduated as a Bachelor of Arts in 1892. In the next year he took his degree in Science. He took his bachelor's degree in medicine in 1894, and received

doctorate in 1897. The greater part of his early professional life was spent in the service of the Lunacy Department of New South Wales. He was appointed to the position of Junior Assistant Medical Officer on June 1, 1895, and he retained some connexion with the Department until he left Australia on military service two years ago. Early in his career in the Department he evinced interest in pathological work, and when it was decided to establish a pathological laboratory in the Lunacy Department in 1900 his qualifications and tastes showed that he was eminently suited for the position of director. He received his appointment as Pathological Director in March of that year. The new laboratory was established to carry out research work, and not to supersede the clinical laboratories already existing in the mental hospitals. Dr. Flashman strongly advocated the location of the research laboratory at the Medical School of the University, so as to receive the benefit of association with the scientific staff of the University. The Inspector-General of the Insane (Dr. Eric Sinclair) was able to arrange for suitable accommodation in the Medical School, and the laboratory remains in the University at the present time. On taking up his new duties, Dr. Flashman devoted some years to neurological studies, and attained a considerable knowledge of the anatomy of the central nervous system. With his friend, Professor J. T. Wilson, he made many preparations of the brain, and studied the different methods of advancing anatomical knowledge. Some years later he was accustomed to conduct classes in the Department of Anatomy on the morphology of the brain and spinal cord as an Honorary Demonstrator of Anatomy. The wealth of material that he used to illustrate his demonstrations was an evidence of the industrious manner in which he had employed his time. To many of us who are Australian students these demonstrations gave for the first time an opportunity of seeing actual preparations of many nervous structures. Many will look back with pleasure to the delightful hours of instruction when their wish to learn led them to attend these classes or to visit the laboratory to see what was exhibited. To all who revealed any sign of interest in the structure of the nervous system he gave of his best without stint.

In 1903 Dr. Flashman visited Europe. He had recognized that it was essential that his laboratory should follow the scientific path along which the great pathological institutions of Europe were travelling. He wished also to meet those men whose tastes and pursuits were similar to his own. While he was away he worked with Eyre on bacteriological methods, with Mott and with Ford Robertson. During this visit he married in 1904 Irene Flora, daughter of Dr. James Dewar, F.R.C.S.E., of Drylaw House, Midlothian. Dr. Dewar was a naval surgeon, and two of his sons are naval surgeons at the present time. One was present at the Battle of Jutland, and came through that fight untouched. When Dr. Flashman left for military service his wife and two children—one a boy of eight and the other a girl of three years—followed him to England. They all survive him. Our sympathy is extended to them.

Returning with his newly-married wife to Australia, Dr. Flashman started to carry out investigations suggested by the experiences of his travels. He wrote a report to the Inspector-General, giving his views on the position of the pathology of insanity at that time, and referring to his hopes for progress from an advance in knowledge. He formulated plans for the methodical accumulation of information, which have been put in operation. Although the University had given him more extended quarters, he asked for a larger laboratory, in which research on a scale adequate to the problems studied could be undertaken. During his travels Dr. Flashman had seen how impossible it was for one man to cope with the whole of the work necessary for progress in a study of insanity. He endeavoured to interest medical officers at the mental hospitals, students and others in the work going on within his laboratory, and to encourage them to commence studies of their own. The liberality of his views and his earnestness and enthusiasm attracted a number of men to start work on his benches.

Within the next few years his scientific publications appeared. He could not help but be drawn to a study of the brain of the Australian aboriginal. His friendship with his fellow-student at the University, Professor G. Elliott Smith, had led him to take particular notice of the studies on the brain of the fellaheen. Flashman endeavoured to trace the same developmental changes between the brain of the European and the brain of the Australian native. He investigated with special care the parietal region of the brain, where the motor centres are situated, and the *area striata* of the occipital lobe. At the same time he commenced some studies of the medullated tracts and nuclei in the brain stem of marsupials. This work, on which much time was spent, was never completed. He hoped at one time that he might have the opportunity of combining physiological and morphological methods for the study of the comparative anatomy of the marsupial nervous system. The only papers that he published on this subject were some short communications on the motor centres and cortico-spinal tracts of dasyurus. These studies all ceased when he found that it would be necessary for him to abandon his neurological work and to proceed to practice medicine for a living. A number of attempts were made by those aware of his talent for investigation and of his industry and energy to persuade the Government to create a post which might retain his services for scientific studies. It was not to be, and one more who might have conferred high honour on Australia by advancing the progress of knowledge was forced to abandon science to earn a sufficient living. The work carried out in the laboratory was published in the first and second volumes of the Reports from the Pathological Laboratory of the Lunacy Department which appeared from 1902 to 1910 in parts. In addition to morphological studies they contain some bacteriological and biochemical papers. The more important of these deal with the method of diagnosis by means of complement deviation and with the part played by diphtheroid organisms in general paralysis of the insane. In the first paper, in collaboration with Dr. Graham Butler, he studied the meaning of Wassermann's test for syphilis. In the second paper, in collaboration with Dr. Oliver Latham, he tested a theory of Ford Robertson under Australian conditions.

In 1909 he became, during the absence of Professor Welch, Acting Professor of Pathology in the University of Sydney. He was very successful as a teacher. On the re-

turn of Professor Welch he continued to take a share in the teaching duties of the Department of Pathology until he left for the front.

In 1910 he started practice as a consultant in neurology and pathology. He achieved success. His ripe knowledge of diseased conditions supplied him with the requisite information of the ailments of his patients. His excellent judgement made him skilful in diagnosis, and helped him to avoid errors. His good fellowship and kindly heart gained him the confidence of his patients. To him used to come many of his personal friends and acquaintances when stricken with illness. They had great confidence in his ability to give them sound advice. He still remained Director of the Laboratory of the Lunacy Department, and carried on some few investigations of a scientific nature. He became an Assistant Physician to the Royal Prince Alfred Hospital, and for some time had charge of the Dispensary of that hospital concerned with the treatment of tuberculosis.

Colonel Flashman took much interest in military matters. He was an officer in the Sydney University Scouts for years, and finally became commanding officer of that battalion. He devoted much time to this work, and studied with characteristic thoroughness under the direction of Colonel Hubert Foster (now a Brigadier-General and Chief of Staff to the Commonwealth of Australia). When war broke out he was much exercised in mind as to whether his duty lay as a combatant or non-combatant officer. After deliberation he decided that his professional skill would be more valuable, and he departed for England in charge of a medical unit.

Dr. Flashman will be remembered for his liberal views and his generous character. He had many interests of diverse characters. He was a popular member of the Royal Sydney Golf Club. He was greatly appreciated by his scientific colleagues, who shared his love of knowledge. He was a life-member of the Royal Society of New South Wales, and frequently attended the meetings. For some years he was a member of the Linnean Society, where he satisfied his liking for biological phenomena. He was the life and soul of many a merry gathering seeking the joys of life. His wide humanity enabled him to share with many their joys and sorrows. His enlightened mind enabled him to appreciate the ideas and aims of many who were little understood by their fellows. *Defunctus adhuc loquitur* has been suggested by an old friend as a suitable heading for a memorial to him.

Dr. Charles MacLaurin writes:—

It was a very great shock to many of us to hear of the death of poor Flashman at the early age of 47; to me personally it came with the added grief of losing one of my oldest friends, who had been endeared to me still further by his long friendship with the late Brigadier-General MacLaurin, and I feel that I should write a few words in memory of his kindly goodness. Early in 1915 Colonel Flashman was appointed O.C. of the Convalescent Depôts in England, and, as it was at first understood that there was to be an Australian surgical hospital in the Old Country, he asked me to accompany him as operating surgeon, an offer which I gladly accepted. Later on it was found that there would be no need for a surgeon in his command, and so he went away with a unit which was largely medical, only to discover when he reached England that there were plenty of patients but no organized hospital or convalescent depôts at all. It is not too much to say that, at that time, the medical services of the Australian forces in England were in a bad way; no one knew anything or had power to settle anything; there seems to have been divided control between able men in Melbourne and in Egypt, and, between the two, the men in England could do nothing but complain. Flashman was appointed O.C. of the Australian forces in England, and set himself with remarkable energy and foresight to restore order out of chaos. He perceived that the Gallipoli campaign would not last very long, and that, in any case, there was sure to be a great number of men needing attention in England, even if the whole Australian army were not to be moved over to France. He therefore decided to move into much larger premises, and, when I reached England a few weeks later, he was already looking round for a suitable position. It is to him that we owe the great offices which now reflect so much credit on Australia in Horseferry Road, and he in a surprisingly short time got together a competent staff and an organization which was already becoming very large when his term of office came to an end. The inner story of those couple of months is not likely to see the light now; but the results of his work were evident immediately. Instead of being depressed and bewildered, everyone took new hope and confidence, as they felt that their affairs were in strong hands and that a clear brain was directing their lives and destinies; and the effect on Australian opinion in London was nothing short of wonderful. Those critics who thought at the time that Flashman was working on too large a scale, that he had planned an organization far in excess of our possible needs, have been proved in error by the march of events; and it is now universally acknowledged that the only possible place where our sick and wounded can be efficiently treated, once they leave the front, is England. I hope that the great part which Flashman took in forming this opinion will in time be recognized by everyone. The great organization which he built up was already too small when General Howse took command, and there are far more workers at Horseferry Road than Flashman ever dreamt of. It is certain that in the few weeks he was at the head of affairs in England he showed remarkable energy, foresight and organizing power, and Australia has good cause to be grateful to him.

Later on Flashman was transferred to Wandsworth, as a first-class clinician was needed there, in accordance with an agreement which had been entered into with the War Office, and, although he was bitterly disappointed that he should be unable to follow his work to its completion, he never complained, but set himself loyally to do his best in his new position. Later on he became quite reconciled, entered joyfully into the medical work, with many of the ablest physicians in London as his colleagues, and I believe that the year or more that he spent at Wandsworth was one of the happiest periods of his life. I know for a fact that he held his own, even in the eyes of the residents, and we all know how hard it is for an outsider to come in and impress the intensely critical spirit of youth. He formed many friendships, and was extremely popular, and not only so, but he was genuinely respected and beloved. He worked very hard, not only at Wandsworth, but also at outside medical studies, and spent many hours every week at different hospitals in learning all that was to be learnt about the diseases of the heart and their scientific diagnosis. With his great charm of manner, genial kindness of heart, and real scientific knowledge, it is not be wondered at that many people thought he would be able to make a success if he decided to remain in London as a consulting physician after the war.

All the time he was secretly studying French, as he foresaw that sooner or later he would be sent to the front, and in a few months he had acquired remarkable fluency and correctness of grammar and idiom, showing in this the same foresight and energy as he had shown at Horseferry Road. When at last his chance came I have no doubt that he welcomed it, and it is a very great loss to Australia that so few weeks were granted to him at Boulogne by a greater Power than the Commonwealth.

Kindly, genial, friendly, able—these words sum up "Jack" Flashman. I never heard him speak of ill of anyone. If he had evil thoughts he kept them to himself. He was always open to new ideas; his mind was quick, receptive and often original. He was a good man to call into consultation, because he always gave a good working opinion, and he had a great influence over wavering patients. When I took up the new surgery of the brain some years ago he sent me my first patient, and for that I shall always have reason to be grateful to him. We have lost in him a good physician and a good, kind, and able man, and I do not know that one can say higher praise than that.

Dr. A. E. Mills writes:—

By the death of Lieutenant-Colonel Flashman another gap is made in the list of my great friends. He and I had known one another intimately for many years. When he was appointed O.C. of a unit that was to go to England to take charge of the Australian Convalescent Depôts there I was not surprised when he asked me to become a member

of that unit. We knew one another, we trusted one another, we each felt we could work together with perfect harmony, and, during the many months we were together, our relations were of the most friendly character, for I recognized that he had one purpose in view, to devote his whole time and all his talents to the work he had to perform.

When we arrived in England we found the Australian Medical Service there in a state of chaos. Colonel Flashman had specific instructions to take charge of the two Convalescent Depôts in England and, if necessary, to establish an additional one. He found that no Convalescent Depôts existed. At first he was entrusted by Sir George Reid with the partial control of the First Australian Auxiliary Hospital at Harefield, later he was placed in supreme command of all the sick and convalescent Australian soldiers in England. This was no light task, for there were thousands under his control, and there was no suitable organization to deal with them. In this position Colonel Flashman showed he possessed the gifts of organization in a high degree. He threw himself wholeheartedly into the work he was confronted with. He grappled with difficulties and overcame them. He was prompt in dealing with questions and made his decisions quickly. He never shelved or postponed the settlement of a question that had to be dealt with. This was in marked contrast to the policy previously practised. He established at Horseferry Road an organization for dealing with the hundreds of soldiers who were constantly reporting there from all parts of England. This organization remained in full working until General Howse came to take charge of the Medical Services of the A.I.F. in England and France. This well-organized department was a complete success, and a striking testimony to the foresight and commonsense of its originator, Colonel Flashman. It was here that my friend laboured for many months. Day after day and night after night he was to be found working away, evolving order out of chaos and dealing in a commonsense manner with all the difficulties that presented themselves before him. When he had got matters running smoothly and satisfactorily, those in supreme authority, with a complete want of recognition of work well done, so often, alas! characteristic of men in military authority, removed him from the position he filled so well and appointed him one of the physicians at Wandsworth Hospital, where some 500 beds are at the disposal of Australian sick and wounded officers and men.

Here again Colonel Flashman worked with energy and interest. His colleagues, British and Australian, regarded him as a man who knew his job and did it faithfully and well. His patients there held him in the highest esteem. Many have spoken of him to me as "a real white man," the highest praise an Australian bestows. His was a very human nature; he was very sympathetic, and many a poor soul he helped along with his encouraging personality. But, in addition, he laboured well to get at the real cause of his patient's illness. Here his sound knowledge of pathological processes was of great help to him. At all times he tried in dealing with disease to have it on pathological or physiological processes. Could be he otherwise than successful? I knew he was keen to go to France, where, at Boulogne, in the pursuit of his duties, serving his country with unstinted energy, he gave his life. His death has caused me the loss of a dear and true friend. By his death the profession has lost a great worker and a keen student, the community at large has lost one who worked to help his patients willingly and with uncommon zeal, irrespective of fee or reward.

Correspondence.

THE MEDICAL PROFESSION AND THE WAR.

Sir,—Last November Surgeon-General Sir N. R. Howse discussed with me the wastage of medical officers. He also mentioned how detrimental to health and how unfair it was to keep a medical officer away from Australia and practice for more than two years,

At present 496 medical officers are serving in the A.I.F. The wastage is about 20%, that is, about 100 medical reinforcements are required annually. The war is not going to end this year, nor next year. Of these reinforcement, should they offer, about 50 will be required with the Divisions at the front; the remainder will be required at Australian hospitals in France, England and Egypt, also in depôts, training battalions, A.M.C. detail camps and medical stores. Young graduates are most suitable for employment in the divisions and members of hospital honorary staffs under 50 years of age will find much scope for their work in the hospitals. The Melbourne hospitals sent all their best men.

More than 150 medical officers served under my command in the A.N.Z.A.C.; they were keen, energetic and efficient; they did excellent work. They often wondered, as their ranks were depleted by death, wounds and sickness, why more medicos were not enlisting. Disappointment was expressed when mention was made of fellow graduates who had excelled in sport and scholarship and were remaining behind. My officers were very pleased they were serving, and really felt so sorry for those who could and ought to serve but preferred comfort and cash to duty.

There is probably much truth in Ian Haig's "First Hundred Thousand" wherein it is remarked that the "best men are all oot" at the front.

REUTER E. ROTH, Colonel,
Formerly D.D.M.S. to 2nd A.N.Z.A.C.

Sydney, February 17, 1917.

ENTERIC FEVER AND SOIL CONTAMINATION.

Sir,—In your issue of February 10, 1917, there is an editorial which criticises the belief that disturbance of the soil by sewerage excavations, in areas previously contaminated by typhoid discharges, can cause a localized outbreak of that disease. I have seen several outbreaks in institutions when the disease appeared to be limited to patients who came in contact with the locality which was disturbed by the excavations, and in these cases there was no contamination by careless workers. The conditions prevailing when excavations are being made through areas which are interlaced by old, leaky drains from laundries and kitchens, pockets of all kinds, etc., such as one finds in the yards of long established institutions, differ very much from those which are present in digging up a street or paddock, and I think, judging from my own observations, that "the student of hygiene" may have some justification for blaming the soil disturbance. Certain strains of the typhoid bacillus are more resistant than others, and the following examples will show a wide range in the powers of endurance of that organism.

1 hour at 56° C. to kill the ty. bacillus for vaccines (Kolmer).

5 minutes at 60° C. to kill the ty. bacillus for vaccines (Muir and Ritchie).

Half an hour at 60° C. to kill the ty. bacillus (Muir and Ritchie).

The typhoid bacilli may live eleven months in the soil (Robertson).

The bacilli of typhoid may live twenty-one days in garden earth (Osler).

May be, "the eminent civil servant" whose action is criticized is quite aware of recent ideas on the subject, but previous experiences such as I have related may have taught him caution until there is more unanimity in the results of the researches concerning the length of time the typhoid organism can live *ex corpore*.

Yours, etc.,
W. A. T. LIND.

18 Walpole Street, Kew.
(Undated).

[Dr. Lind puts forward three arguments in support of the contention that the *bacillus typhosus* can exist for long periods in soil and retain its vitality and virulence. The first is based on impressions, and if unsupported by definite data cannot be regarded as scientific argument. The second has little to do with the problem in question. We concede readily that the bacillus may show a varying resistance to heat, and that, under varying conditions, may survive temperatures of 56° or 60° C. for varying periods of time. The third is entirely fallacious. He quotes two eminent authori-

ties, one in administrative hygiene and the other in the science and theory of medicine, as having stated that the typhoid bacillus may live for a certain length of time in soil. Neither of these gentlemen are bacteriologists, and neither have determined experimentally how long the bacillus can survive in soil. Where they obtained their information from we do not know, but we venture to assert that recent investigations by competent bacteriologists have revealed that they are mistaken.]

Medical Appointments.

Dr. John Murray Sanderson has been appointed Acting Government Medical Officer, Thursday Island, and Visiting Surgeon to his Majesty's Prison, Thursday Island, during the absence of Dr. Norman Walter Markwell.

Dr. Lachlan Martin McKillop has resigned his position as Government Medical Officer at Blackall, Queensland. Dr. Paul Réné Loubet has been appointed in his stead.

Dr. P R. Loubet has been appointed Visiting Surgeon to the Blackall Police Gaol.

During the absence of Dr. John Steell, Dr. Donald Albert Campbell has been appointed Acting Medical Superintendent of the Hospital for the Insane, Yarra Bend, Victoria.

Dr. Henri Victor David Baret, Junior Resident Medical Officer, Waterfall Sanatorium, New South Wales, has been appointed Assistant Medical Officer at that institution as from January 1, 1917.

Dr. Alan Pryde has been appointed House Surgeon of the Launceston General Hospital in succession to Dr. L. O. Macnamara, who has resigned. The appointment is to take effect from January 1, 1917.

In pursuance of the provisions of "The Insanity Act of 1884" Dr. Charles De Wolfe Heard has been appointed Third Assistant Medical Superintendent, Hospital for the Insane, Goodna, Queensland.

His Excellency the Governor of Queensland has been pleased to approve:—

(1) That the resignation of Dr. Harvey Sylvester Walsh, Part-time Medical Inspector of Schools, be accepted; to take effect as from the 30th June, 1916;

(2) That Dr. James Lee Selwood be appointed temporarily, as from the date of his entry on duty, as Part-time Medical Inspector of Schools, Brisbane, during the absence of Dr. Croll; and

(3) That Dr. Selwood be exempted from the operations of the Public Service Acts and the Public Service Superannuation Act.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxi.

Brisbane Hospital, Junior Resident Medical Officers.

Normanton District Hospital, Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
SOUTH AUSTRALIA. (Hon. Sec., 8 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

Feb. 27.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Feb. 28.—Vic. Branch, B.M.A., Council.
Mar. 2.—Q. Branch, B.M.A., Branch.
Mar. 7.—Vic. Branch, B.M.A., Branch.
Mar. 9.—S. Aust. Branch, B.M.A., Council.
Mar. 13.—N.S.W. Branch, B.M.A., Ethics Committee.
Mar. 13.—Tas. Branch, B.M.A., Council and Branch.
Mar. 15.—Vic. Branch, B.M.A., Council.
Mar. 15.—N.S.W. Branch, B.M.A., last day for Nomination of Candidates for Election of Council of Branch.
Mar. 16.—Q. Branch, B.M.A., Council.
Mar. 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Mar. 21.—W. Aust. Branch, B.M.A., General.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.